HOSPITAL PAYMENT UNDER MEDICARE

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ONE HUNDRED SECOND CONGRESS

FIRST SESSION

FEBRUARY 27, 1991

Serial 102-10

Printed for the use of the Committee on Ways and Means

U.S. GOVERNMENT PRINTING OFFICE
43-582
WASHINGTON : 1991

For sale by the Superintendent of Documents, Congressional Sales Office
U.S. Government Printing Office, Washington, DC 20402

H781-37

COMMITTEE ON WAYS AND MEANS

DAN ROSTENKOWSKI, Illinois, *Chairman*

SAM M. GIBBONS, Florida
J.J. PICKLE, Texas
CHARLES B. RANGEL, New York
FORTNEY PETE STARK, California
ANDY JACOBS, Jr., Indiana
HAROLD E. FORD, Tennessee
ED JENKINS, Georgia
THOMAS J. DOWNEY, New York
FRANK J. GUARINI, New Jersey
MARTY RUSSO, Illinois
DON J. PEASE, Ohio
ROBERT T. MATSUI, California
BERYL ANTHONY, Jr., Arkansas
BYRON L. DORGAN, North Dakota
BARBARA B. KENNELLY, Connecticut
BRIAN J. DONNELLY, Massachusetts
WILLIAM J. COYNE, Pennsylvania
MICHAEL A. ANDREWS, Texas
SANDER M. LEVIN, Michigan
JIM MOODY, Wisconsin
BENJAMIN L. CARDIN, Maryland
JIM McDERMOTT, Washington

BILL ARCHER, Texas
GUY VANDER JAGT, Michigan
PHILIP M. CRANE, Illinois
DICK SCHULZE, Pennsylvania
BILL GRADISON, Ohio
BILL THOMAS, California
RAYMOND J. McGRATH, New York
ROD CHANDLER, Washington
E. CLAY SHAW, Jr., Florida
DON SUNDQUIST, Tennessee
NANCY L. JOHNSON, Connecticut
JIM BUNNING, Kentucky
FRED GRANDY, Iowa

Robert J. Leonard, *Chief Counsel and Staff Director*
Phillip D. Moseley, *Minority Chief of Staff*

Subcommittee on Health

FORTNEY PETE STARK, California, *Chairman*

MARTY RUSSO, Illinois
BRIAN J. DONNELLY, Massachusetts
WILLIAM J. COYNE, Pennsylvania
SANDER M. LEVIN, Michigan
JIM MOODY, Wisconsin
BENJAMIN L. CARDIN, Maryland

BILL GRADISON, Ohio
ROD CHANDLER, Washington
NANCY L. JOHNSON, Connecticut
RAYMOND J. McGRATH, New York

CONTENTS

Page

Press release of Wednesday, February 13, 1991, announcing the hearing 2

WITNESSES

Prospective Payment Assessment Commission, Stuart H. Altman, Ph.D., Chairman, and Donald A. Young, M.D., Executive Director 12

U.S. Department of Health and Human Services, Gail R. Wilensky, Ph.D., Administrator, Health Care Financing Administration 57

American Hospital Association, Paul Rettig 98

Anderson, Gerard F., Ph.D., Center for Hospital Finance and Management, Johns Hopkins University 73

Long, Hugh W., Ph.D., A.B. Freeman School of Business, Tulane University, and Medicare Geographic Classification Review Board 79

National Association of Public Hospitals, Larry S. Gage 107

National Council of Community Hospitals, John Horty 123

National Rural Health Association, Robert T. Van Hook 118

SUBMISSIONS FOR THE RECORD

Association of American Medical Colleges, statement and attachments 138

Association of Minority Health Professions Schools, David Satcher, M.D., statement 151

National Committee to Preserve Social Security and Medicare, Martha McSteen, statement 135

University of Pittsburgh Medical Center, Thomas Detre, M.D., statement 154

HOSPITAL PAYMENT UNDER MEDICARE

WEDNESDAY, FEBRUARY 27, 1991

House of Representatives,
Committee on Ways and Means,
Subcommittee on Health,
Washington, D.C.

The subcommittee met, pursuant to notice, at 11:07 a.m., in room 1100, Longworth House Office Building, Hon. Fortney Pete Stark (chairman of the subcommittee) presiding.

[The press release announcing the hearing follows:]

FOR IMMEDIATE RELEASE
WEDNESDAY, FEBRUARY 13, 1991

PRESS RELEASE #2
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1102 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
TELEPHONE: (202) 225-7785

THE HONORABLE PETE STARK (D., CALIF.), CHAIRMAN, SUBCOMMITTEE ON HEALTH, COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES, ANNOUNCES A HEARING ON HOSPITAL PAYMENT UNDER MEDICARE

The Honorable Pete Stark (D., Calif.), Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, announced today that the Subcommittee will hold a hearing on hospital payment by the Medicare program. The hearing will be held on Wednesday, February 27, 1991, beginning at 10:00 a.m. in room 1100 Longworth House Office Building.

Oral testimony will be heard from invited witnesses only. However, any individual or organization may submit a written statement for consideration by the Subcommittee and for inclusion in the printed record of the hearing.

BACKGROUND

The Prospective Payment Assessment Commission is required to report on March 1 of each year regarding the Commission's recommendations for the Medicare hospital payment update used to increase hospital payments in each fiscal year. This report will be presented at the hearing by the Chairman of the Commission.

Testimony will also be presented by the Administrator of the Health Care Financing Administration regarding the changes in Medicare payments to hospitals proposed by the President in his budget.

Statements will also be presented by academic experts and hospital representatives regarding the fiscal status of the hospital industry in 1991.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

For those who wish to file a written statement for the printed record of the hearing, six (6) copies are required and must be submitted by the close of business on Wednesday, March 13, 1991, to Robert J. Leonard, Chief Counsel, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. An additional supply of statements may be furnished for distribution to the press and public if supplied to the Subcommittee office, 1114 Longworth House Office Building, before the hearing begins.

FORMATTING REQUIREMENTS:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages.
2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.
3. Statements must contain the name and capacity in which the witness will appear or, for written comments, the name and capacity of the person submitting the statement, as well as any clients or persons, or any organization for whom the witness appears or for whom the statement is submitted.
4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and public during the course of a public hearing, may be submitted in other forms.

Chairman STARK. The Subcommittee on Health of the Committee on Ways and Means will begin to hear testimony regarding payments to hospitals under the Medicare program.

I am pleased to welcome once again Dr. Stuart Altman, the Chairman of the Prospective Payment Assessment Commission, and other distinguished witnesses to the subcommittee today.

I am also pleased to welcome the subsequent arrival of Dr. Gail Wilensky, Administrator of the Health Care Financing Administration. We have all enjoyed working with Stuart and Dr. Wilensky on the many questions which always provide some tension but never become contentious. And for the first time in several years, we are meeting today at the beginning of our legislative Congress without a reconciliation bill either pushing or pulling us, and we will be working based on last year's budget summit agreement. For the first time in many years we are not considering legislation to cut Medicare payments based on instructions in a budget resolution.

This gives us the opportunity to catch our breath more or less and assess the response of the hospital industry to the cost problems and the incentives in the prospective payment system. And I must suggest that the industry's record would give us reason to think there is room for improvement. Since the beginning of the prospective payment system, hospital payments per admission have grown at twice the rate of general inflation, and the only problem is that hospital expenses have risen even faster than twice the rate of general inflation. The net result is, of course, that margins continue to fall.

As we suggested last year at this time, the problem of hospitals is not a shortfall in revenue. There is a problem of excess consumption. The spending of hospitals has increased about 10 percent a year for each year of the prospective payment system. If the spending had been under control, the margins would be far above where they are now. I understand that we probably have 6,000 of the finest executives in the United States employed in the hospital industry, brilliant men and women, well-trained, and it seems to me that they should be far better able than the executives of the auto industry or the banking industry or the savings and loan industry to bring these costs under control.

I am concerned that the hospitals are now attempting to increase income from other payers instead of working on the expense side. And I would also like to brag a little about the Medicare system which I came to late in its life, but nonetheless this subcommittee has actively been involved in setting policy for the Medicare system, and we have a system that has controlled costs. But we must spread that cost containment to every patient regardless of their sponsorship. The experience with an all-payer rate program at the State level shows that costs can be contained when payments by all payers are controlled or when there is a single payer.

The overall failure to control costs does not take away from the one payer, Medicare, which has been having success. This year we will spend a great deal of time investigating how to assure every American adequate health protection. As a part of that effort, we will be assessing how to control costs across the board not just for a single payer. I think our witnesses today are going to provide us with some interesting ideas on how best to proceed.

[The opening statement follows:]

OPENING STATEMENT OF THE HONORABLE PETE STARK CHAIRMAN, SUBCOMMITTEE ON HEALTH

Today the Subcommittee will hear testimony regarding payments to hospitals under the Medicare program.

I am pleased to welcome once again Dr. Stuart Altman, Chairman of the Prospective Payment Assessment Commission, and our other distinguished witnesses to the Subcommittee.

I am also pleased to welcome the Administrator of the Health Care Financing Administration, Dr. Gail Wilensky. We have all enjoyed working with Dr. Wilensky on the many contentious questions with which the Medicare program presents us.

For the first time in several years, the Subcommittee is not meeting today to begin deliberations pursuant to reconciliation legislation. Based upon last year's budget summit agreement, and the provisions of OBRA '90, we will not be considering legislation to cut Medicare hospital payments based upon instructions contained in a budget resolution.

Since we do not have to focus on budget reconciliation, we have an opportunity to stop, catch our breath and assess the response of the hospital industry to the cost containment incentives included within the prospective payment system.

I must admit that the industry's record does not look good. Since the beginning of PPS Medicare's hospital payments per admission have grown at approximately twice the rate of general inflation. More troubling, hospital managers are allowing hospital operating expenses to rise even faster.

The net result is that margins continue to fall.

As I said last year at this time, the current problems of hospitals are not due to shortfalls in revenue. It is a problem of excess consumption. Hospital spending has increased about ten percent per year for each year of PPS.

If hospital spending had been brought under control, margins would be far above where they are now.

Of course, I am concerned that hospitals are now attempting to increase payments by other payers, instead of controlling expenses across the board. Given our relative success with Medicare, we need to turn our attention to how we can achieve meaningful cost containment for every patient, regardless of sponsorship.

The experience with all-payer rate regulation programs at the state level clearly show that costs can be contained when payments by all payers are controlled, or when there is a single payer. The failure to do so does not take away from the one payer, Medicare, which has been having success.

This year the Subcommittee will spend a great deal of time investigating how to assure every American adequate health protection. As part of that effort, we will be assessing how to control costs across the board, and not just for a single payer.

I hope our witnesses today will provide us with new insight on how to proceed.

Chairman **Stark**. Before I proceed with our first witness, Congressman Dorgan of the Ways and Means Committee has asked to present a statement.

STATEMENT OF HON. BYRON L. DORGAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NORTH DAKOTA

Mr. **Dorgan**. Mr. Chairman, thank you very much for allowing me this time at the start of this hearing. I will be very brief. We have made some progress in the area of rural health care, and especially in the area of responding to financial needs of rural hospitals. But I wanted to make a statement today to ask the chairman and the subcommittee to be continually mindful of the special needs that exist in rural America and the special financial problems faced by rural hospitals. Congressman McGrath was in North Dakota with me last year, and so he knows something about the special needs in rural areas. And Mr. Chairman, you know from testimony that I have offered previously that often in rural hospital settings, 70 to 75 percent of the people who walk through the front door for treatment in a rural hospital are Medicare patients.

So the question of how we fund Medicare is critically important to the economic health of a rural hospital because if we do not fund it appropriately, they are not able to make up for Medicare shortfalls on private pay patients. Rural hospitals do not have patient base that is sufficient enough to shift costs. Now I want to commend you, Mr. Chairman, and the subcommittee, for the work that we have done together under your leadership on the EACH program. I think that we are starting to move down the road to make some important strides to respond to these needs, and especially the improvement on the sole community hospital program has been important. North Dakota now has 34 sole community hospitals. That is almost triple from previous numbers as a result of the improvements we have made in that program.

In recent months in North Dakota there have been two hospital closures and a third has now lost its physician and is open on a nonemergency basis. I want to relate to you one of these closures, the one in Beach, N. Dak. In Beach, as a result of the hospital closure, someone who suffers a critical illness or an accident is now going to be an hour from the nearest hospital. And I watch the news in the evening here in Washington, D.C., and I hear tremendous criticism of the ambulance service because they were delayed 10 or 15 minutes, and I would join in that criticism obviously. But I am equally outraged when I hear about the people who face an hour travel to the nearest hospital as a result of their problems because of a hospital closure in a rural area.

We have continual problems of financial pressure on rural hospitals which is resulting in increasing closures. Another aspect of that entire problem is the difficulty in attracting physicians to rural areas. I am hopeful that as you look at the picture this year with respect to rural health care and hospital reimbursements that you and I and others can work on a program once again that would build on the success we have had in establishing the EACH programs and also develop approaches that will attempt to find ways to encourage physicians to practice in rural America and in rural hospitals.

In my mind, this is a priority for rural America especially because access to health care is critically important. Cost is important, yes, indeed, but access is more important than cost. If you do not have access when you need it in an emergency you are in deep trouble. That is a life or death decision in rural America. That is not a convenience or an inconvenience. So if you would be willing to continue to work with us recognizing we still have hospitals that face threatened closure, we still have difficulty attracting physicians, we need to build on the success in the sole community hospital program, build on the EACH program and other approaches. We must find a way to encourage physicians to practice in rural areas. I think we will have a very productive year and I appreciate the leadership you have given in the past, and I look forward to working with you, Mr. Chairman.

[The prepared statement follows:]

OPENING STATEMENT OF THE HONORABLE BYRON L. DORGAN
BEFORE THE COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH HEARING ON
HOSPITAL PAYMENT ISSUES FOR FISCAL YEAR 1992

FEBRUARY 27, 1991

Mr. Chairman, thank you for once again allowing me the opportunity to appear before the Health Subcommittee today to talk about hospital payment issues under the Medicare program. As you know, I have appeared before this Subcommittee on previous occasions to discuss the impact that Medicare payments to hospitals have had on rural health care delivery. At the outset, I want to express my deep gratitude and appreciation for the active role you and other Members of this Subcommittee have taken in recent years to address the unique needs of rural hospitals. I think that this Subcommittee has made some significant and positive contributions to the many policy changes that have been enacted in recent years which are designed to rectify some of the inequities in Medicare payments and help rural hospitals. Despite this progress however, rural hospitals continue to struggle and the Congress cannot rest in the continuing fight to save access to health care in rural areas.

RECENT ADVANCES FOR RURAL HOSPITALS

The budget reconciliation measures enacted in the past few years have included some important advances for rural health care delivery. For instance, OBRA 1990, the five year budget reconciliation bill, provides for the elimination of the urban/rural differential in the standardized rate by fiscal year 1995. When the Prospective Payment System was enacted in 1984, the differential in the standardized rate was over 20 percent. Adjustments to the update factors for rural hospitals in budget reconciliation measures since that time have slowly narrowed the gap between rural and urban payments. Although the OBRA 1990 provisions phase-out this differential by 1995, a differential still remains because of other adjustments such as the wage index and others. But, at least the arbitrary geographic discrimination in the standardized rate will no longer be an issue.

Prior to OBRA 1990, the budget reconciliation measure from the year before included many significant provisions that will significantly improve Medicare payments to rural hospitals. The most notable changes in Medicare payments to rural hospitals are: the establishment of the Essential Access Community Hospital (EACH) program and significant improvements to the Sole Community Hospital program. In its May 1990 report to Congress on "Medicare Payments to Rural Sole Community Hospitals and Small Rural Hospitals'" the Prospective Payment Assessment Commission (ProPAC) estimated that the new Sole Community Hospital rules enacted by OBRA 1989 would increase per-case payments to Sole Community Hospitals by 10 percent on average. I know that these changes will help many rural hospitals in North Dakota. Prior to the changes made in OBRA 1989 for the Sole Community Hospital program, only eleven North Dakota rural hospitals participated. Since the changes, this figure has tripled.

Instead of having to close hospitals, the EACH program offers rural communities other options by encouraging state-wide coordination of rural health care services and allowing rural hospitals to adjust the scope and mission of their facilities to adapt to the changing rural health care environment. Although these changes are only beginning to be implemented, I anticipate that rural hospitals will benefit significantly.

RURAL HOSPITALS CONTINUE TO STRUGGLE

However, I am certain that we have yet to achieve "the answer" to save rural health care delivery. Despite these advances, rural hospitals continue to struggle. Over the past three years, more than 100 rural hospitals have closed. In each of those years, rural hospital closures accounted for more than 50 percent of total hospital closures. The 1991 figures on hospital closures will include at least 2 North Dakota hospitals that recently were forced to close their doors and another is literally on the verge of closing. These closures raise serious concern about access to health care in some areas of the state.

I understand that the factors that lead to the closure of a rural hospital can be multiple and indeed Medicare has been part of the problem in many cases. In each year of the Prospective Payment System (PPS), average PPS operating margins have been substantially lower for rural hospitals than for other hospitals. In the past few years, rural hospitals, on average, have endured negative PPS operating margins. When 70 or 80 percent of the patients served in small rural hospitals are Medicare patients, as is the case for many rural hospitals in North Dakota, that facility is essentially a Medicare-dependent facility. And when those hospitals continue to lose money treating Medicare patients, it is only a matter of time until they will fail.

MEDICARE OBLIGATION: ENSURING ACCESS

It seems to me that if we are going to fulfill our obligation to provide health care services to Medicare beneficiaries, then the Medicare program must keep facilities open that are critical to access -- like in remote rural areas. The May 1990 ProPAC report observed that "Medicare cannot ignore other issues that potentially affect continued access to hospital care for current beneficiaries, as well as for future beneficiaries." The Commission went so far as to say that "Medicare should interpret its responsibility to program beneficiaries more broadly that just focusing on the payment of Medicare operating costs. It is clear that, for certain rural hospitals, Medicare may need to pay more than its share of costs to keep needed hospitals open." Clearly, the purpose of the Medicare program is provide basic health care services to the elderly and the disabled. Although it is not the case that a closure of a hospital always means that this purpose is hindered, in the case of a rural hospital closing it can often mean no access to health care for some Medicare patients.

One of the hospitals that closed recently in North Dakota was the only hospital in a rural community located 61 miles from the nearest hospital in the state. Forty miles across the border into Montana lies another rural hospital. The closure of this hospital means that the residents of this community are at least **one hour from health care services.** If an elderly Medicare patient has an emergency, they will have to pray that they can last at least an hour without the attention of a nurse or physician while they drive 40 or 60 miles to the hospital down the highway.

In Washington, D.C. we are outraged when we hear of an ambulance being delayed for 15 or 20 minutes to pick up someone in an emergency. My question is: where is the outrage when someone who lives in a rural community is an hour away from health care, when they were once minutes away?

PHYSICIAN SHORTAGE PROBLEMS

I understand that rural hospitals fail for a number of reasons: low occupancy, high dependency on Medicare payments for revenues, and shortage of physicians. The two North Dakota hospitals that have closed this year share a common problem -- lack of physician coverage. The other rural hospital is on the verge of closing for the same reason. One hospital had to shut down literally within days after their only physician left without much notice, giving the community no time to find another physician. In light of what I have seen happen in North Dakota recently, I am convinced that we cannot separate discussion of Medicare Part A payments to rural hospitals from the issue of attracting and retaining health care professionals such as physicians, nurse practitioners, and physician assistants in rural areas.

Rural communities are having increasing difficulty finding physicians to cover their rural hospitals. For example, in 1988, 111 rural counties in the United States had no physician at all and 176 counties had no MD. At the present time, there are at least 16 rural communities in North Dakota seeking to locate a physician through the National Health Services Corps program and because of limited resources, only a few will be filled. If we are going to commit resources into keeping rural health care facilities open, we have to dedicate physician retention and recruitment for rural service an equal priority.

Existing programs, such as the National Health Service Corps, are not enough. It seems to me that approaches in addition to loan repayment and scholarships need to be pursued to attract physicians and other health care professionals into rural areas.

CONCLUSION

In conclusion, despite the fact that several policy changes have been enacted that will benefit rural health care delivery, we cannot pretend that we have done enough. Although I believe that the impact of the changes made in the past two years will help rural hospitals, these facilities continue to struggle. It imperative that we monitor the ever changing rural health care delivery environment and respond accordingly to ensure that access to health care is ensured for urban and rural residents alike.

Thank you Mr. Chairman.

Chairman **Stark**. Well, I want to thank the gentleman from North Dakota for his comments, and review just for the record that this committee has worked closely and harmoniously with what now has been formalized into the Rural Health Caucus, a bipartisan caucus in the House. And as the gentleman recalls, the same problems, although multiplied, are shared by many of us here. The gentleman from Wisconsin to your left has hospitals in his district that are unable to serve the community and/or are closing. And last year, just to review, we came to what I thought was for inner city and for rural hospitals, a very generous package.

It was $2 billion for inner-city and $1 billion for rural hospitals. And I think it was unanimously accepted by the members of this subcommittee and by the Rural Health Caucus as being fair. Quite frankly, our colleagues in the other body destroyed the agreement by suggesting that it ought to be a billion apiece. We have always felt on this side that a deal is a deal. And I think that we have to stay together as we did. But we must recognize those with whom we must hammer out our agreements in the future to hold what has been, and I hope will continue to be, a strong coalition of those who want to provide access to all Americans who are disadvantaged by geography or income.

And I look forward to working with the gentleman and the Rural Caucus and all the members of the subcommittee because I do not think it comes as any surprise that Medicare often subsidizes all health care in this country. That does not trouble me. I just wish we had more money to increase those subsidies for a lot of programs, and I appreciate the gentleman's help and his support of this subcommittee's work. Thank you very much.

Mr. McGrath.

Mr. **McGrath**. Thank you, Mr. Chairman, and Dr. Altman, members of the ProPAC, let me welcome you to receive your recommendations this year. And I appreciate your testimony. I am a new member of this subcommittee, having been on the committee, the Ways and Means Committee, for a long time. I pointedly stayed away from this subcommittee until it got to the point where I was required to do so out of my own particular needs at home in New York. I represent an area in New York, and in my former life I was the ranking member of the assembly health committee. So I do have some knowledge in this area, and some of the things in prospective payment that we have recently done here at the Federal level, we did in New York long before. So I am well aware of some of these remedies that are being suggested.

Along with touring North Dakota with my colleague, Mr. Dorgan, I have been recently, since being elected to this subcommittee, touring New York State hospitals. I have been to Syracuse, and I met with the central New York region, and to Rochester recently at Strong Memorial Hospital. I will be meeting with the, hopefully, western New York and northern western New York region. Just Monday I was at Albany Med Center for the capital region. I will be in Westchester County for the Hudson Valley region this Friday. Let me suggest to you that what I am hearing is of great concern to me. We are a little bit different than perhaps many of the other hospitals and States in the Nation. We are a very regulated State where certificates of need and other things that perhaps do not exist in other States exist in our State, almost to the point of being retarding to the ability to provide quality care.

At the same time, we have been very successful in holding down the costs of care. I hope that the recommendations that we promulgate hopefully this year will be helpful to those who have been earnestly trying to stay within the purview of our recommendations in the past, and given, perhaps given some consideration for the circumstances in which they have to deal with on a day-to-day basis. So I will be continuing my travels to New York City and to Nassau-Suffolk on Long Island and to Buffalo. In each of the cases I am hearing problems with Medicare, with the new proposed capital regulations, and with what the chairman has suggested might be helpful for the rest of the country, and that is the coupling of Medicare rates with other third-party payers, which we already have in New York.

So I am interested in your testimony. Hopefully, it will be reflective of the needs of the people I represent in the area of the State of New York, and I look forward to hearing from you.

Chairman **Stark**. Thank you.

Our first witness is Dr. Stuart Altman, the Chairman of the Prospective Payment Assessment Commission. He is accompanied by Dr. Don Young, who is Executive Director of the Commission. Stuart, proceed to enlighten us.

STATEMENT OF STUART H. ALTMAN, PH.D., CHAIRMAN, PROSPECTIVE PAYMENT ASSESSMENT COMMISSION, ACCOMPANIED BY DONALD A. YOUNG, M.D., EXECUTIVE DIRECTOR

Mr. **Altman**. Thank you, Mr. Chairman. First, let me tell you how pleased I am to be here. The relationship between ProPAC and this committee and your staff has been just fantastic. I think we, I know we try to be as helpful as we can, and back and forth between you and the members of this committee as well as the staff has been a source of personal satisfaction, great satisfaction, over the years, and I really appreciate it.

As you indicated, I am here accompanied by Dr. Donald Young, who is the Executive Director of ProPAC. On Friday, we will be delivering the seventh annual report and recommendations for updating and improving Medicare payment policy for hospitals and other facilities. As you well know, the Omnibus Budget Reconciliation Act of 1990 significantly expanded ProPAC's responsibilities, and our report this year reflects this broader mandate. In developing our report and recommendations, we were very mindful of the current fiscal environment and the budget deficit agreement that set Medicare payment rates for future years.

Financial pressures, however, intensify the need to address the distributional and technical payment issues that may affect access and quality of care for Medicare beneficiaries, and, therefore, we believe it is important for us as an advisory commission to you to continue to go through our mechanisms for apportioning those increases and setting an update factor. Medicare's prospective payment system, as you know well, is in its eighth year. And as you pointed out, PPS has affected hospital payments in two very important ways. Medicare per case payments can now be controlled through the annual update process, and PPS has significantly affected the distribution of Medicare payments across hospitals.

As a result, Medicare inpatient hospital spending slowed dramatically with the implementation of PPS as shown in table 1 in my testimony. The 6 years before PPS, Medicare inpatient spending was growing at an annual rate of 17 percent. Over the first 6 years of PPS, the annual growth rate fell to about 6.1 percent. This decrease in the rate of growth was due clearly, in part, to Medicare's ability to control the level of per case payment, but was also related to a lower level of general inflation and a decrease in hospital admissions. As you pointed out, Mr. Chairman, on a less optimistic note, hospital expenses per admission, which dropped significantly in the first year of PPS, since then has grown and expenses have now averaged over the last several years 10 percent a year.

This continued growth in per admission expenses at roughly twice the general rate of inflation is of particular concern to the Commission. It highlights, I think, the limitations of PPS by itself to be an effective mechanism for controlling hospital expenses. ProPAC is continuing to analyze whether the effectiveness of PPS can be improved by changes in Medicare payment alone or if systemwide changes are required. There is also the real issue of whether hospital administrators by themselves can control many of the items that drive their expenses up.

Our analysis suggests that a major factor for the continued growth in per case costs are the increases in the number of new tests and procedures that are ordered by physicians and the extra costs of administering the DRG system. With our broader mandate, we will be studying the relationship between Medicare payment policies and those of us other payers and examining different approaches to paying for health care services. We also will be looking at whether changes in the payment system can influence the ordering of new tests which have been demonstrated to be of only very limited value.

Because costs per case are now growing faster than payments, many hospitals are experiencing declines in their financial condition. Now there are many ways of looking at the financial conditions of hospitals, but one way is to look at their margins. And we have looked at two types of margins. One are called the PPS margins which compare hospital payments from the PPS system with the costs that are associated with treating Medicare patients. PPS margins were very high in the first 2 years of PPS. Medicare was quite generous to them. But since then, the continued growth in costs combined with much smaller increases in payments has resulted in sharp declines in PPS margins. These are shown, by the way, in our figure 1.

By the fifth year of PPS, 1988, the aggregate PPS margins were about 2.6 percent. We estimate that in 1990 the aggregate margins were actually a negative or minus 2.5 percent. But there is another way of looking at hospitals' financial conditions, and that is their total margins, which look at the overall financial shape of American hospitals, compare their total intake of funds to their total outflow of dollars or expenses. And when you look at total margins, you also see that while there was a decrease from the beginning of PPS, the decrease was not as steep as the PPS declines.

And in the last several years, total margins for hospitals have leveled off and continued to be on the positive side, and are higher than they were at any time during the 1970s. And one of the things that we have tried to do, Mr. Chairman, is not only present you with PPS margins, but to keep you apprised of what is going on with total margins as well.

While the Commission is concerned about the financial conditions of many hospitals, it is also mindful that total Medicare payments have grown by more than 9 percent per year since PPS began. We, are, therefore, recommending an update factor that while stringent should generate an increase in Medicare inpatient payments of over 7 percent a year when projected increases in Medicare admissions are considered. This is in line with recent trends in Medicare payments for inpatient services. Now, if you will permit me, Mr. Chairman, I would like to briefly describe our recommendations for Medicare hospital payments in fiscal year 1992 as well as some of our additional concerns.

As you know, Mr. Chairman, in fiscal 1992 the update has been set by law. Nevertheless, as you have requested, the Commission followed its past approach by examining individual factors that together determine the updated recommendation. Our average update factor recommendation for 1992 is an average of 3.4 percent based on the current HCFA market basket forecast of 4.8 percent. We are recommending a 3.2 percent update for large and other urban hospitals and 4.2 percent for rural hospitals. The details and components of these recommendations are included in our table 2, and I will not go into them unless you are interested.

Thus, the Commission update recommendation is the same as the current law 1992 update for both urban and rural hospitals. The increase in Medicare payments to hospitals, however, will be much more than the average update of 3.4 percent. We estimate that average per case payments to hospitals in 1992 will increase an additional 2.3 percent due to continued increases in reported case mix, and our recommendation also reflects an increase that will generate over 7 percent in total payments because of an expected increase in hospital admissions.

Since the beginning of PPS, urban and rural hospital payments have been determined by different base payment amounts. In our March 1990 report, the Commission recommended that the difference between the rural and other urban standardized amounts be eliminated. Consistent with OBRA 1990 provisions to accomplish this by fiscal year 1995, we are recommending a higher update for rural hospitals of 4.2 percent compared to 3.2 percent for urban hospitals. Mr. Chairman, I would now like to turn to the teaching and disproportionate share hospital payment. This year as previously we have attempted to balance Medicare's responsibility to provide an appropriate level of payment for the costs associated with teaching intensity and the care of indigent patients with a broader Federal responsibility to maintain access to high quality care for Medicare as well as other patients.

This year the Commission estimated the relationship between teaching intensity and Medicare operating costs without first adjusting for the disproportionate share payment. We use this approach because we believe the IME and the disproportionate share adjustment are designed to meet different policy objectives even though there is substantial overlap in the hospitals receiving these adjustments. Omitting the disproportionate share adjustment from the analysis increases the estimated teaching intensity effect from 2.1 to 4.2 percent. We believe this 4.2 percent figure based on the method we've used this year is the most appropriate method of measuring the added cost related to teaching intensity.

The current 7.7 percent IME adjustment is substantially higher, we recognize, than the 4.2 percent. As a result of this and other factors, PPS operating margins have consistently been much higher for teaching hospitals than for nonteaching hospitals. However, as we pointed out to this committee last year, one should not only look at PPS margins, and when you look at overall financial performance of major teaching hospitals, their position is not nearly as attractive as would be suggested by PPS margin, and, in fact, they look relatively poor in terms of their financial conditions relative to other hospitals.

These findings led us to be very mindful of how much of a reduction we should recommend in the teaching adjustment. We are very concerned that these major hospitals in our health care system be financially sound enough to continue to provide the quality care we expect of them. As a result, the Commission is recommending a modest reduction in the IME adjustment from its current 7.7 percent level to a 7 percent for fiscal 1992. The recommendation would reduce the IME adjustment by one-fifth of the difference between the current level and the Commission's empirical estimate of 4.2.

This reduction should be implemented in a budget neutral fashion with the reductions in indirect medical education payments returned to all hospitals with corresponding increases in the standardized payment amounts. We would further suggest that before recommending any further cuts in the IME adjustment in future years, the Commission and the Congress examine carefully the financial status of teaching hospitals to determine whether reductions would have serious deleterious effects on Medicare patients' access to high quality care. As you know, Mr. Chairman, psychiatric and rehabilitative hospitals and distinct part units as well as long-term children's and cancer hospitals are exempt from PPS. These hospitals and units are subject to payment policies established in the Tax Equity and Fiscal Responsibility Act of 1982.

They are paid on the basis of each facility's historical costs trended forward with a limit placed on the rate of increase in per case payments. The TEFRA target rate of increase limits are updated annually. Until 1989, these excluded facilities received the same update as provided by PPS hospitals. However, the PPS hospital updates are constrained because PPS hospitals also received increases due to their increase in case mix. For the first 7 years, therefore, the PPS payments increased nearly 70 percent while the market basket was only a 35 percent increase. At the same time, the TEFRA target rate hospitals increased by only 27 percent. PPS excluded providers, therefore, received substantially lower payment increases than the PPS hospitals.

In addition, facilities which were excluded from the beginning of PPS were at greater disadvantage than facilities that were excluded at a later date because of the fact that they received this lower payment. The Commission's analysis indicates that the earlier a provider was excluded from PPS, the more financially vulnerable it became. The Commission believes that these excluded providers should have received the full increase in the market basket each year they were excluded prior to 1989. Therefore, the Commission update factor recommendations for excluded hospitals has two components.

First, we are recommending an average update for all excluded hospitals and distinct part units of 4.2 percent which uses our same technical structure as in the past. But second, we are recommending an additional positive allowance to some hospitals to compensate them for the years that TEFRA facility payment was subject to the PPS update factor. This additional allowance reflects the difference between the updates given in early years and the actual market basket for these years. Now we believe that with this adjustment, we will be correcting much of the payment inequities resulting from the use of the PPS update factor prior to 1989. But also one of the reasons why I feel so strongly about this is that we now have a bureaucratic mess out there because many of these hospitals are forced to come in on a complicated administrative procedure to seek special exemptions from HCFA. They ultimately receive it. It generates a lot of extra paperwork, and seems to us to be a burden that we can avoid by giving these hospitals the extra payments based on what we consider to be their legitimate needs and just letting it go at that.

We also have two other recommendations that I would like to briefly mention. First, in OBRA 1990 you asked us to report on modifications in the area wage index to remove the effects of variations in the mix of occupations employed. We are recommending that the Secretary prospectively collect data on employee compensation and paid hours of employment for hospital workers by occupational category. The Secretary should then use this data to implement an adjustment that would correct for the inappropriate inclusion in the wage index of geographic differences in the mix of occupations employed. Basically what we are saying is this. Hospitals have at their disposal a rich mix of different types of workers they choose to use. The richer the mix or the more technically competent, the higher salary these individuals are paid. That winds up being reflected in the wage index but really is not a wage issue, and currently, we believe overcompensates some hospitals and undercompensates others.

I would now like to turn briefly to the subject of Medicare payments for capital costs. Since the beginning of PPS, it has been intended that hospital capital costs would be incorporated within the DRG payment system. Capital continues to be paid on a cost basis, however, for technical and other reasons. The major problem is that capital costs more than operating costs vary significantly across similar institutions. This variation is due to many factors including differences in timing of major capital investment and various financial methods.

The capital costs associated with major projects extends over many years. Therefore, hospital managers have limited ability to adjust existing capital to adapt to changing financial incentives. The Commission had originally planned to submit our capital policy recommendation to you in our March 1 report. We made these plans believing that the Secretary's proposal would be available to us and the Congress well in advance so that we would have time to evaluate it and analyze its impact. However, we have not yet had the opportunity to review the Secretary's proposals. Therefore, we are deferring our recommendations until we can assess this proposal, and if appropriate suggest modifications or an alternative payment approach.

We have presented you with some very preliminary information which suggests that Medicare payments for capital have been growing at about the same rate as operating expenses, but we are concerned that there not be any extra incentives built into the capital payment that would encourage overcapitalization. And, therefore, we are very interested in reviewing in detail the new proposal that the administration has come forth with to see if it meets those criteria.

We have been encouraged to find that in the past few years the rate of increase in capital, as I mentioned, has declined significantly, but it is still growing at a sizable rate in line with, as I said, operating expenses. As you requested, Mr. Chairman, the Commission will submit a capital report and a recommendation to you by May 15, 1991.

Congress has asked us to report in March of 1992 on hospital outpatient policy. In our report this year, we outline a framework for this payment reform. Our preliminary analysis strongly suggests that outpatient hospital services should be paid on a prospective basis. Furthermore, where possible, a comprehensive outpatient facility payment system should include all providers of outpatient services and should have incentives that are consistent with the physician payment reform approach recently passed by Congress. We believe that Medicare payment incentives should not lead physicians or beneficiaries to inappropriately select one site of care over another. We are recommending improved data collection and uniform coding and billing requirements. We are also recommending that services provided in the hospital outpatient setting should be included in the Medicare physician volume performance standard if these services are included when provided in other settings.

I realize this is a complicated issue, and could be controversial, but in our view it is very important that we not set up a set of incentives that encourage, again, the same type of services to be done in one system or area versus another simply because of the way we pay for it.

Finally, Mr. Chairman, I would like to comment on the problem of uncompensated care, which in OBRA 1990 asked us to consider. As you and members of the subcommittee know, many Americans lack health insurance or other means to cover the cost of medical care. ProPAC is concerned about the effects of this problem on access to care for millions of Americans as well as the increasing financial burden it places on hospitals and other providers that care for the uninsured population.

From 1980 to 1989 uncompensated care costs in PPS hospitals increased an average of 12 percent per year. Further, the proportion of uncompensated care costs that were not offset by State and local government subsidies increased even faster during this period by about 13.5 percent. In 1980, State and local governments covered almost 30 percent of all uncompensated care costs. This proportion had dropped to 20 percent by 1989. Therefore, uncompensated care continues to be a significant problem for all hospitals, particularly for large, inner-city, and publicly owned institutions. However, over the course of the last decade, the problem has increasingly affected the entire industry.

After offsetting Government subsidies, uncompensated care commands the same proportion of hospital resources in rural areas as it does in urban. Public hospitals, as we expect, continue to provide the most uncompensated care. But the proportion of all unpaid care borne by these hospitals has declined from 27 percent in 1980 to 16 percent in 1989. Similarly, the proportion provided by teaching hospitals decreased from 23 percent to 18 percent. Further, there is substantial variation in the proportion of hospital resources devoted to uncompensated care in both urban and rural areas and among regions of the country. There is also great variation among teaching and nonteaching hospitals, and even among Government hospitals.

This tremendous diversity complicates the task of addressing any uncompensated care payment policy. Before we or I draw any conclusions about the pattern of uncompensated care across hospitals or what might be done to mitigate its negative effects, we plan to add to our analysis the impact of providing care to Medicaid patients often at payment levels below costs. We will subsequently report to you the findings from this analysis. We certainly share the interest of this subcommittee in the problems of the uninsured and its impact on hospitals and other providers and the American people as well. We would be pleased to work with you on this problem and in particular to find ways to assist those hospitals with the greatest need. Mr. Chairman, this completes my testimony, and I would be more than happy to answer any questions. Thank you very much.

[The prepared statement follows:]

STATEMENT OF STUART H. ALTMAN, PH.D., CHAIRMAN PROSPECTIVE PAYMENT ASSESSMENT COMMISSION

Good morning, Mr. Chairman. With me today is the Commission's Executive Director, Dr. Donald A. Young. I appreciate the opportunity to testify before the Subcommittee this morning. Friday, ProPAC will be delivering its seventh annual report and recommendations for updating and improving Medicare payment policies for hospitals and other facilities. The Omnibus Budget Recommendation Act of 1990 significantly expanded ProPAC's responsibilities. Our report this year reflects this broadened mandate.

The concern that Medicare beneficiaries have access to high-quality care has guided our deliberations. The Commission, however, believes that access to high-quality care does not mean unrestrained spending. Continued efforts are necessary to slow the rate of increase in spending for hospital and other services. Hospital managers and physicians caring for patients have to make some difficult choices to control the growth in hospital expenses and improve hospital financial performance.

In developing our report and recommendations, we were mindful of the current fiscal environment and of the budget deficit agreement that set Medicare payment rates for future years. Financial pressures, however, intensify the need to address distributional and technical payment issues that may affect access and quality of care for Medicare beneficiaries. Therefore, we believe that our recommendations and concerns are important for the Congress and the Secretary to consider as the opportunity arises to improve payment policy.

The Status of Hospitals

Medicare's prospective payment system (PPS) is in its eighth year. PPS has affected hospital payments in two important ways. First, Medicare per-case payments can now be controlled through the annual update process. Second, PPS has significantly affected the distribution of Medicare payments across hospitals because payment per-case is related to the average cost of treating that type of case rather than on each hospital's actual cost.

As a result, the growth of Medicare inpatient hospital spending slowed dramatically with the implementation of PPS (Table 1).

Table 1. Estimated Inpatient Hospital Payments

	Inpatient Hospital	
Fiscal Year	Payments (In Billions)	Percent Change
1977	$14,429	–
1978	16,719	15.9%
1979	19,176	14.7
1980	23,129	20.6
1981	27,708	19.8
1982	32,554	17.5
1983	36,950	13.5
1984	40,386	9.3
1985	43,618	8.0
1986	45,280	3.8
1987	46,579	2.9
1988	49,570	6.4
1989	52,642	6.2
Annual rate of change:		
1977-1983		17.0
1983-1989		6.1

Note: Payments reported in this table are incurred expenditures, rather than outlays.

SOURCE: Health Care Financing Administration, Office of the Actuary.

The 6 years before PPS, Medicare inpatient spending was growing at an annual rate of 17 percent. Over the first 6 years of PPS, the annual growth rate fell to 6.1 percent. This decrease in the rate of growth was due in part to Medicare's ability to control the level of per-case payments, and was also related to a lower level of inflation and a decrease in hospital admissions.

On a less optimistic note, while hospitals' expenses per admission dropped significantly in the first year of PPS, since then, expenses have grown almost 10 percent a year.

The continued growth in per-admission expenses at roughly twice the general rate of inflation is of particular concern to the Commission. It highlights the limitations of PPS by itself as an effective mechanism for controlling hospital expenses. ProPAC is continuing to analyze whether the effectiveness of PPS can be improved by changes in Medicare payment alone or if system wide changes are required.

With our broader mandate, we will be studying the relationship between Medicare payment policies and those of other payers and examining different approaches to paying for health care services.

Because costs per-case are now growing faster than payments, many hospitals are experiencing a decline in their financial condition. One way to assess a hospital's financial condition is to examine its financial margins. (Figure 1)

The PPS margin compares the PPS payments that hospitals receive with their Medicare operating costs. PPS margins were very high in the first two years of PPS. Since then, however, the continued growth in costs, combined with much smaller increases in payments, has resulted in a sharp decline in PPS margins. By the fifth year of PPS (1988), the aggregate PPS margin was 2.6 percent. In 1990, we estimate the aggregate margin was a minus 2.5 percent.

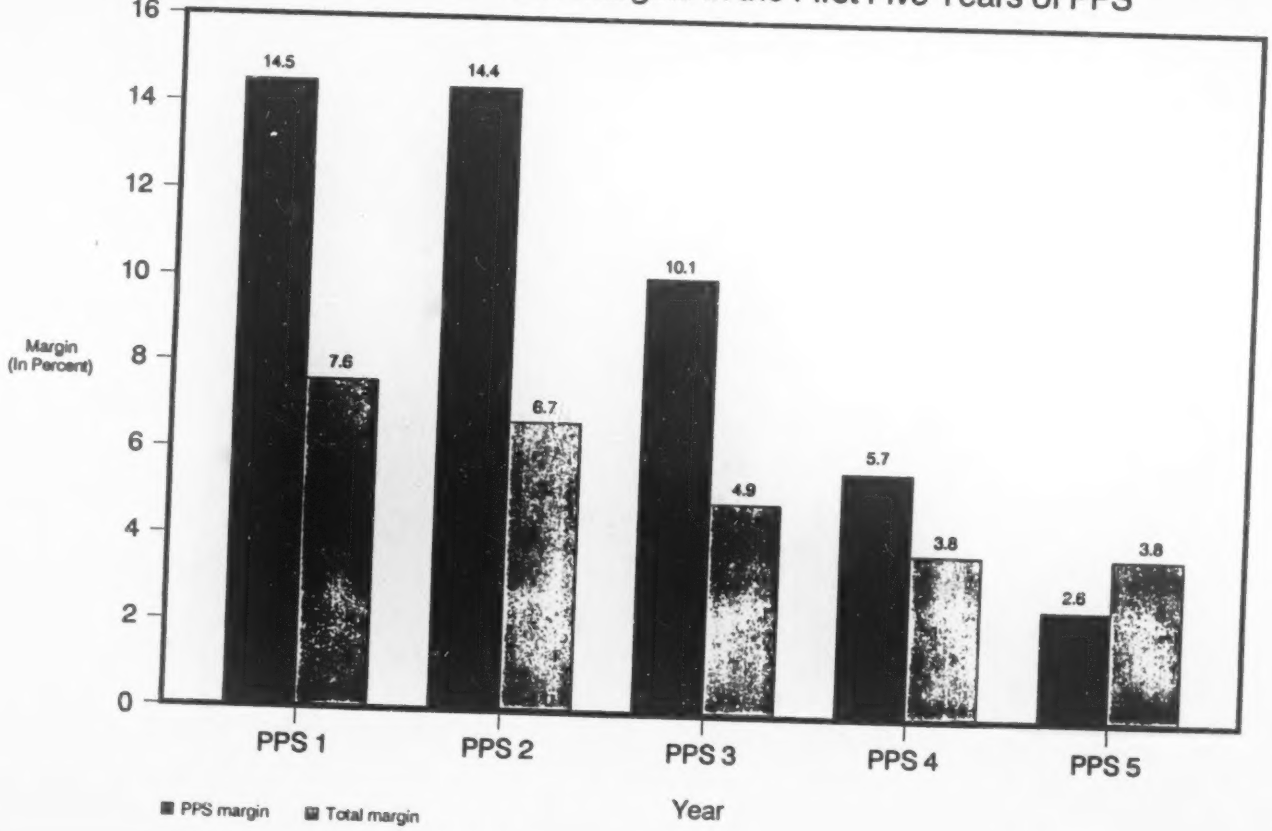
Another measure of the financial performance of a hospital is the total margin which describes hospitals' overall financial status. The total margin compares hospital revenues and expenses for all inpatient and outpatient care and non-patient care activities. This includes Medicare and Medicaid patients, patients covered by private insurance and those who are uninsured. Non-patient care activities are also included.

As with the PPS margin, the total margin declined over the first five years of PPS. This decrease, however, was not as steep as for the PPS margin. The decline in total margins has now leveled off and remains at about the same level as immediately before PPS. Total margins today, are considerably higher than they were at any time during the 1970s.

While the Commission is concerned about the financial condition of many hospitals, it is also mindful that total Medicare payments have grown by more than 9 percent per year since PPS began. We are therefore recommending an update factor that, while stringent, should generate an increase in Medicare inpatient payments of about 7 percent for fiscal year 1992, when projected increases in Medicare admissions are considered. This is in line with recent trends in Medicare payments for inpatient services.

Mr Chairman, I would now like to briefly describe our recommendations for Medicare hospital payment in fiscal year 1992 and some of our additional concerns.

Figure 1. PPS and Total Margins in the First Five Years of PPS



SOURCE: Medicare Cost Report data from the Health Care Financing Administration.

Update Factor for 1992

As you know, Mr. Chairman, the fiscal year 1992, update has been set by law. Nevertheless, as requested by Congress, the Commission followed its past approach of examining individual factors that together determine its update recommendation.

Our average update factor recommendation for 1992 is 3.4 percent, based on the current HCFA market basket forecast of 4.8 percent. We are recommending a 3.2 percent update for large and other urban hospitals and 4.2 percent for rural hospitals. The detailed components of these recommendations are shown in Table 2.

Table 2. Recommended PPS Update Factors for Fiscal Year 1992

Components of the Update Factor		
Components applied to all hospitals:		
Fiscal year 1992 PPS market basket forecast*		4.8%
Adjustment to reflect ProPAC version of PPS market basket*		0.2
Correction for fiscal year 1990 forecast error		- 1.0
Components of discretionary adjustment factor		
Scientific and technological advancement	0.7	
Productivity	- 0.5	
Total discretionary adjustment factor		0.2
Adjustments for case-mix change (fiscal year 1991)		
Total DRG case-mix index change	- 2.5	
Real DRG case-mix index change	1.3	
Within-DRG case complexity change	0.2	
Net adjustment for case-mix change		- 1.0
Additional adjustments to the standardized amounts:		
Adjustment for large urban areas	0.0	
Adjustment for other urban areas	0.0	
Adjustment for rural areas	1.0	
Total Update Factor		
Large urban	3.2	
Other urban	3.2	
Rural	4.2	
Average update factor		3.4

* Market basket forecast provided by the Health Care Financing Administration, Office of the Actuary, December 1990. The market basket forecast is subject to change as more current forecasts become available.

Thus, the Commission's update recommendation is the same as the current law 1992 update for both urban and rural hospitals. The increase in Medicare payments to hospitals, however, will be more than the average update of 3.4 percent. We estimate that average per-case payments to hospitals in 1992 will increase an additional 2.3 percent due to continued increases in reported case mix. Our recommendations, therefore, would result in a total increase in average PPS per-case payments of 5.7 percent (see Table 3).

Table 3. Estimated Fiscal Year 1992 Average Increase in Per-Case PPS Payments

PPS update factor	3.4%
Estimated case-mix index change (fiscal year 1992)	2.3
Total increase in average PPS payments*	5.7

* Most of the increase in payments resulting from case-mix index change will be offset by the increased costs of treating sicker patients.

When expected increases in Medicare admissions are factored in, we expect total Medicare payments for inpatient hospital care to increase by about 7 percent.

Since the beginning of PPS, per-case payments have increased faster than the update factor as shown in Figure 2 and Table 4.

Table 4. Changes in PPS Payments

Fiscal Year	Market Basket	PPS Update	Increase in PPS Payments Per Case
1984	4.9%	4.7%	18.9%
1985	4.0	4.5	10.3
1986	3.1	0.5	3.4
1987	3.5	1.2	4.6
1988	4.8	1.5	5.8
1989	5.5	3.3	5.4
1990	4.5	6.0	7.0
Cumulative			
1983-1990	35	24	70

As you can see, over the first seven years of PPS, the cumulative increase in the update factor was 24 percent. Per-case payments, however, increased by 70 percent. In comparison, the hospital market basket measure of inflation increased by 35 percent over this period.

Rural Hospital Payment

Since the beginning of PPS, urban and rural hospital payments have been determined by different base payment amounts (standardized amounts). In our March 1990 report, the Commission recommended that the difference between the rural and the other urban standardized amounts be eliminated. Consistent with the OBRA 1990 provisions to accomplish this by fiscal year 1995, we are recommending a higher update for rural hospitals of 4.2 percent compared to 3.2 percent for urban hospitals.

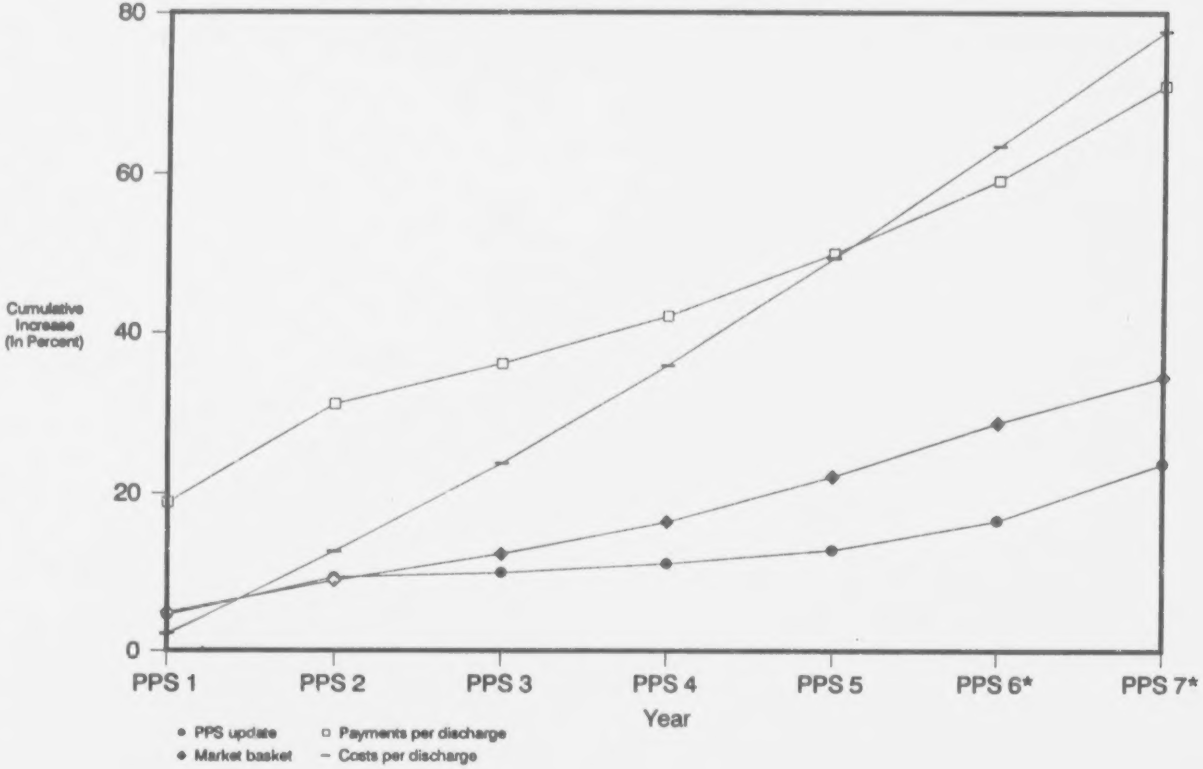
While rural and urban hospitals currently exhibit similar overall financial performance, some rural hospitals continue to fare poorly under PPS. The Commission is continuing its analyses of specific problems facing certain rural hospitals. As requested by the Senate Appropriations Committee, we will submit a report with additional findings and recommendations in mid-1991. These recommendations will suggest policy reforms recognizing the many changes that have already been enacted to reflect the changing pattern of rural health care delivery. We believe that additional policy changes should be tailored to specific problems faced by a subset of rural hospitals, rather than the broad approach of many of the reforms adopted to date.

Teaching and Disproportionate Share Hospitals

Mr. Chairman, I would like to turn now to teaching and disproportionate share hospital payments. This year, as previously, we have attempted to balance Medicare's responsibility to provide an appropriate level of payment for the costs associated with teaching intensity and the care of indigent patients with a broader Federal responsibility to maintain access to high quality care for Medicare as well as other patients.

Each year, ProPAC estimates the relationship between teaching intensity and Medicare operating costs per discharge. To arrive at this estimate, we adjust for other factors that also influence payment, such as urban or rural location, the level of the wage indexes and the hospital's case-mix index. Our most recent analysis is based on cost data from the fifth year of PPS and payment rules for fiscal year 1991.

Figure 2. Cumulative Increases in PPS Costs and Payments Per Discharge, First Seven Years of PPS



* Costs and payments are estimated for PPS 6 and PPS 7.

This year, the Commission estimated this relationship without first adjusting for DSH payment. We used this approach because we believe the IME and the DSH adjustments are designed to meet different policy objectives, even though there is substantial overlap in the hospitals receiving these adjustments. Omitting the DSH adjustment from the analysis increased the estimated teaching intensity effect from 2.1 percent to 4.2 percent. We believe this 4.2 percent figure, based on the method we used this year, is the most appropriate measure of the added costs related to teaching intensity.

The current 7.7 percent IME adjustment is substantially higher than the 4.2 percent indicated by our most recent analysis. As a result of this and other factors, PPS operating margins consistently have been higher for teaching hospitals than for non-teaching hospitals. However, the overall financial performance of major teaching hospitals has been poor relative to other hospitals, in part because these hospitals treat large numbers of patients without private insurance. These findings led us to conclude that the continued operation of these hospitals and the fulfillment of their unique role in the provision of health care would be impaired without continued Federal support.

Therefore, the Commission is recommending a modest reduction in the IME adjustment from its current level of 7.7 percent to 7.0 percent for fiscal year 1992. This recommendation would reduce the IME adjustment by one-fifth of the difference between the current level and the Commission's empirical estimate of 4.2 percent. This reduction should be implemented in a budget neutral fashion with the reduction in indirect medical education payments returned to all hospitals with corresponding increases in the standardized payment amounts. Before recommending any further cuts in the IME adjustment in future years, the Commission will examine the financial status of teaching hospitals to determine whether reductions would have serious deleterious affects on Medicare patients' access to high quality care.

ProPAC will continue to work to improve the IME adjustment so as to better target these extra Medicare payments to those teaching hospitals most in need. At the same time, improvements may also be necessary in the disproportionate share adjustment to fulfill the broader social responsibilities of the Medicare program as efficiently as possible.

PPS Excluded Hospitals and Distinct-Part Units

As you know Mr. Chairman, psychiatric and rehabilitation hospitals and distinct-part units as well as long-term, children's, and cancer hospitals are exempt from PPS. These hospitals and units are subject to payment policies established in the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). They are paid on the basis of each facility's historical costs trended forward, with a limit placed on the rate of increase in per-case costs.

The TEFRA target rate-of-increase limits are updated annually. Until 1989, these excluded facilities received the same update provided to PPS hospitals. The PPS update, however, was constrained because PPS hospitals also received increased payments due to case-mix index increases. For the first seven years, PPS payments increased nearly 70 percent while the market basket increase was 35 percent. At the same time the TEFRA target rate increased only 27 percent. PPS excluded providers, therefore, received substantially lower payment increases than PPS hospitals.

In addition, facilities excluded from the beginning of PPS were at a greater disadvantage than facilities that were excluded at a later date. The Commission's analysis indicates that the earlier a provider was excluded from PPS, the more financially vulnerable it has become.

The Commission believes that these excluded providers should have received the full increase in the market basket each year they were excluded prior to 1989. Therefore, the Commission's update factor recommendations for excluded providers has two components.

First, we are recommending an average update factor for all excluded hospitals and distinct part units of 4.2 percent. We arrived at this figure using the HCFA PPS-excluded hospital market basket forecast of 4.9 percent, and adjusting this market basket to better reflect increasing labor costs, which are not adequately captured in HCFA's market basket. As with PPS hospitals, an adjustment was made to correct for an error of 1.0 percent in the 1990 market basket forecast. We then added an allowance of 0.1 percent for scientific and technologic advancement.

Second, we are recommending an additional positive allowance to some hospitals to compensate them for the years the TEFRA facility payment was subject to the PPS update factor. This additional allowance reflects the difference between the updates given in earlier years and the actual market baskets for those years.

We believe this adjustment will correct the payment inequities resulting from the use of the PPS update factor prior to 1989. This adjustment should ease the financial burden on hospitals most in need and thereby reduce the administrative burden and additional program costs resulting from the many hospitals applying to HCFA for special exceptions to their payment rates.

Other PPS Adjustments

We also have two other PPS recommendations that I would like to briefly mention.

First, in OBRA 1990 you asked us to report on modifications to the area wage index to remove the effects of variations in the mix of occupations employed on hospital wage costs. We are recommending that the Secretary prospectively collect data on employee compensation and paid hours of employment for hospital workers by occupational category. The Secretary should use these data to implement an adjustment that would correct for the inappropriate inclusion in the wage index of geographic differences in the mix of occupations employed.

We do not believe that compensating hospitals through the area wage index for differences in occupational mix across areas is appropriate. These cost differences are either within the hospitals control or are already accounted for by other PPS adjustments.

Second, we are recommending a one-time adjustment to the process of calculating DRG weights for fiscal year 1992. This adjustment would correct payment errors resulting from a change in DRG assignment of heart attack patients, which HCFA implemented in fiscal year 1990.

Capital Payment

I would now like to turn briefly to the subject of Medicare payment for capital costs. Since the beginning of PPS, it has been intended that hospital capital costs would be incorporated within the DRG payment system. Capital continues to be paid on a cost basis, however, for technical as well as other reasons. The major problem is that capital costs, more than operating costs, vary significantly across similar institutions. This variation is due to many factors, including differences in the timing of major capital investments and various financing methods and rates. The capital costs associated with major projects extend over many years. Therefore, hospital managers have limited ability to adjust existing costs to adapt to changing financial incentives or patient demand.

The Commission had originally planned to submit our capital policy recommendations to you in our March 1, 1991 report. We made these plans believing that the Secretary's proposal would be available for our analysis and evaluation. However, we have not had the opportunity to review the Secretary's proposal. Therefore, we are deferring our recommendations until we can assess this proposal, and if appropriate suggest modifications or an alternative payment approach.

During the past year, however, we have conducted extensive analysis and discussions of capital payment issues. Our subsequent recommendations will be guided by our belief that Medicare capital payment policy should generate appropriate incentives for hospitals to limit their capital expenditures and that there should be no extra incentive to increase capital spending as an alternative to labor or other categories of operating expenses. The policy should also, where appropriate, recognize hospitals' prior capital obligations.

We have been encouraged to find that, in the past few years, the rate of increase in capital spending has declined significantly. As inflation in the early 1980s waned, interest costs declined. More recently, however, we have also seen less growth in depreciation, indicating that hospitals are decreasing the amount of capital investment. As a result, capital costs are now increasing at about the same rate as operating costs (see Table 5).

Table 5. Capital/Total Cost and Capital/ Operating Cost Ratios 1980 - 1990 (Annual Percent Change)

Year	Capital/ Total Cost	Annual Percent Change	Capital/ Operating Cost	Annual Percent Change
1980	6.2%	-1.6%	6.6%	-1.5%
1981	6.3	1.6	6.7	1.5
1982	6.5	3.2	7.0	4.5
1983	6.9	6.2	7.4	5.7
1984	7.9	14.5	8.6	16.2
1985	8.3	5.1	9.1	5.8
1986	8.4	1.2	9.2	1.1
1987	8.5	1.2	9.3	1.1
1988	8.5	0.0	9.3	0.0
1989	8.5	0.0	9.3	0.0
1990*	8.4	-1.1	9.2	-1.2

* Data through August 1990 compared to data through August 1989.

SOURCE: ProPAC analysis of American Hospital Association National Hospital Panel Survey.

This decrease in the rate of growth in capital spending seems to be a response to both the current policy of paying less than full capital costs and the increasing financial pressures facing hospitals as Medicare continues to control payments for operating expenses.

As you requested, Mr. Chairman, the Commission will submit a capital report and recommendations to you by May 15, 1991.

Hospital Outpatient Payment

Congress has asked us to report in March 1992 on hospital outpatient payment policy. In our report this year, we outline our framework for this payment reform. Our preliminary analysis strongly suggests that outpatient hospital services should be paid on a prospective basis. Furthermore, where possible, a comprehensive outpatient facility payment system should include all providers of outpatient services and should have incentives that are consistent with the physician payment reform approach recently passed by Congress. We believe that Medicare payment incentives should not lead physicians or beneficiaries to inappropriately select one site of care over another.

We are recommending improved data collection, and uniform coding and billing requirements. We also recommend that services provided in the hospital outpatient setting should be included in the Medicare Physician Volume Performance Standard if these services are included when provided in other settings.

Uncompensated Care

Finally, Mr. Chairman, I would like to comment on the problem of uncompensated care, which OBRA 1990 asks us to consider. As you and the members of the subcommittee know, many Americans lack health insurance or other means to cover the cost of medical care. ProPAC is concerned about the effects of this problem on access to care for millions of Americans and the increasing financial burden it places on hospitals and other providers that care for the uninsured population.

From 1980 through 1989, uncompensated care costs in PPS hospitals increased an average of 12 percent per year. Further, the portion of uncompensated care costs that is not offset by state and local government subsidies increased even faster during this period - by 13.5 percent per year. In 1980, state and local governments covered 29 percent of all uncompensated care costs. This proportion had dropped to 20 percent by 1989.

Uncompensated care continues to be a significant problem for large, inner-city and publicly-owned institutions. Over the course of the last decade, however, the problem has increasingly affected the entire industry. After offsetting government subsidies, uncompensated care commands the some proportion of hospital resources in rural areas as in urban areas. Public hospitals continue to provide the most uncompensated care, but the proportion of all unpaid care borne by these hospitals has declined from 27 percent in 1980 to 16 percent in 1989. Similarly, the proportion provided by major teaching hospitals has decreased from 23 percent to 18 percent.

Further, there is substantial variation in the proportion of hospital resources devoted to uncompensated care in both urban and rural areas and among regions of the country. There is also great variation among both teaching and non-teaching hospitals and even among government hospitals. This tremendous diversity complicates the task of addressing uncompensated care in payment policy.

Before drawing any conclusions about the pattern of uncompensated care across hospitals or what might be done to mitigate its negative effects, we plan to add to our analysis the impact of providing care to Medicaid patients, often at payment levels below costs. We will subsequently report to you the findings from this analysis.

We share the interest of this subcommittee in the problems of the uninsured populations and its impacts on hospitals, other providers, and the American public. We would be pleased to work with you on this problem and in particular to find ways to assist those hospitals with the greatest need.

Mr. Chairman, this completes my testimony. I would be pleased to respond to questions.

Chairman **Stark**. Thank you, Stuart. I would just like to note the arrival of our ranking member, Mr. Gradison, and our former representative of the Rural Caucus, Mr. Pickle, who continues to keep an eye on us. We are glad to have you back, Jake. Mr. Moody is not here. Mr. Coyne.

Mr. **Coyne**. Thank you, Mr. Chairman. There seems to be some ambiguity in defining charity care. Have your studies from hospitals found any consistent definition of what they consider charity care? Has the Commission investigated developing a definition?

Mr. **Altman**. I think you are correct that the definition of charity care is complicated, often is in the eyes of the giver as opposed to the receiver. I think it is fair, and I will have to ask Dr. Young to correct me if I am wrong, but we were limited by our definition to the way Medicare essentially reports these. Is that it?

Dr. **Young**. The information—

Mr. **Altman**. See that was quick.

Dr. **Young**. The information we presented was from the American Hospital Association. The requirements for reporting are for uncompensated care. So the question you ask of a definition of charity care is not directly addressed. That care could be out-of-pocket billing that the patient did not pay. It could be patients for whom there was no payment by any source or for whom there was a partial payment. So we phrased it as uncompensated care, but we were not able to struggle with the question you are asking, how do you separate uncompensated care generally from charity care more specifically.

Mr. **Coyne**. Would it be feasible for the Commission to develop a definition?

Mr. **Altman**. I think we could come up with a definition. I do not think we could then translate that definition into observable differences in numbers until we went back and had the hospitals collect it that way. And as a matter of fact, there has been a significant amount of discussion among the Commission itself on just this issue. For example, some hospitals would like to count as charity care the extent to which they provide services to Medicaid recipients, or Medicare for that matter, and receive less than their average costs. Now that is a debatable issue, but it is one of the areas of contention.

So, (*a*) you are right, it is a problem; (*b*) we were limited by definitions whether it is Medicare definition or the hospital definition; but (*c*) we will be willing, if you are interested, for us to take a crack at a definition.

Mr. **Coyne**. Well, I would be, if you could do that.

Mr. **Altman**. OK. Fine.

Mr. **Coyne**. You pointed out that from 1980 to 1989 there was a 12 percent per year increase in uncompensated care. Can you estimate what the effect would be if uncompensated care was folded into the disproportionate share formula? Could you speculate on that?

Mr. **Altman**. When we made our original recommendation to the Congress on how to create the disproportionate share adjustment, we had suggested that the Congress use total care for all indigent patients including uncompensated care. Because of the first question you asked me, because of the technical difficulties of measuring what that looks like, the Congress chose to focus its definition of the disproportionate share on those patients who were Medicaid patients or those who receive SSI payments, which is only a subset of the total.

I do believe it would be an interesting and maybe more correct to have this broad a definition of uncompensated care included in the definition of what a disproportionate share hospital would look like. I do not know what that would necessarily generate in the form of payments, but you could be assured that it would be a different distribution than currently exists. As a matter of fact, one of the most frustrating aspects of this analysis is that when we try to correlate uncompensated care with disproportionate share payments, the correlation is very poor. And we do not completely understand why that is. We have certain hypotheses why it is. So there is no question a different definition for how you distribute disproportionate share payments would substantially redistribute those payments.

Mr. **Coyne**. Thank you.

Chairman **Stark**. Mr. Cardin.

Mr. **Cardin**. Thank you, Mr. Chairman. I was interested in your finding that capital costs rate of growth has slowed down in recent years. Admittedly, it still has the same rate of increase as operating costs, but it has declined. Could you give us your findings as to why there has been a slowdown in capital in the last several years? We have lowered the reimbursement. Was that a factor? Was the economy a factor? You mentioned interest rates, but with lower interest rates the cost of capital is reduced, which could encourage more capital construction.

Mr. **Altman**. Well, it is very easy to count. It is not so easy to really get behind the reasons why things happen. My own assessment is that a combination of paying capital at a discount of 10 or 15 percent plus stringent controls on operating payments have put in jeopardy many capital investments that might have happened in the past, and therefore they have been cut back. But they have not been eliminated. Capital is still growing at a significant rate but is growing more in line with operating costs than it was in the past. So I think it is fair to say that the combination of those two factors, discount on capital as well as tighter operating payments from Medicare has had an impact on slowing the rate of growth of capital.

Mr. **McGrath**. Would the gentleman yield?

Mr. **Cardin**. I would be glad to yield.

Mr. **McGrath**. I might also suggest that in States like New York where you go through a local HSA process and a State planning and review process to achieve a certificate of need, that takes in excess of perhaps 3 years, might also contribute to that phenomenon.

Mr. **Altman**. Well, as you pointed out, Mr. McGrath, New York is unique. And it is unique in many ways including the fact that it has a much more complicated, stricter capital control system than other parts of the United States. So while I very much appreciate what you say and very sympathetic to what you say, as well, that is not so true in other parts of the country.

Mr. **Cardin.** I am curious. I understand your concern, and when you look at the new recommendations that will be made by the Secretary in regard to reimbursement of capital that you do not want to have incentives there that encourage people or hospitals to shift costs to capital. But the flip side is also true. Have you done any studies as to the needs for capital improvements at the hospitals and whether the system is now putting on the brakes too quickly where we may be faced with a catch-up problem in the not too distant future where hospitals are postponing capital needs that will just build for future costs.

Mr. **Altman.** Need is a very difficult term to really deal with in this industry. This is an industry that has had access to capital at a very substantial rate. The answer is ProPAC has really not done a hospital by hospital or area by area analysis of capital needs. My own personal opinion is that this is an industry that has not suffered from any appreciable lack of capital. As a matter of fact, I think you would be hard-pressed to find any industry in the United States that has had the ready flow of capital of this industry. Now there is no question that if you really put the brakes on tight that at some point that can come back to hurt.

And I would go back to Mr. McGrath and New York. I think it was fair to say that New York put its foot very hard on the brake for a lot of very legitimate reasons, I might add, perhaps in the early, in the middle 1970s and the 1980s, and then has had a very rapid growth in certain parts of the State in new capital coming on line in the last couple of years. But I do not think the country is anywhere close to where New York was in, say, 1985 in terms of capital. If it is anything, I think what the chairman indicated is pretty accurate, and that is that we have excess capacity around the country as well as bringing on line a lot of new equipment. But over time it could be an impact.

Mr. **Cardin.** Let me just ask one more question following up on Mr. Coyne's comments. One of your findings that surprised me is that uncompensated care is being spread more evenly, it looks like, over the hospital community than it was last year. At least there is a trend toward spreading the uncompensated care. And that sort of surprised me because my own observations would have led to the opposite conclusion. I am wondering whether part of that shift might relate to the point that Mr. Coyne was making regarding what is now being considered. Uncompensated care may well be influenced by the accounting practices of individual hospitals that really perhaps confuse the issue with charitable care. Maybe charitable care still is very concentrated among few hospitals.

Mr. **Altman.** I am very sympathetic to Mr. Coyne's and your comment. I have not been able to reconcile this information either. In the sense that by laying open the definition, uncompensated care, to anything that the hospital chooses to define as uncompensated care, puts those numbers at risk. On the other hand, it is fair to say that there is other evidence that suggests that over the last decade more and more hospitals have been forced to or have been willing to generate care to people who cannot pay their bills. Now, there is a big difference, though, in how each type of hospital gets paid for the fact that it does not receive payment for some of its hospitals.

We have created a three tiered group of hospitals, I think, in this country. Let us for the sake of an argument use the numbers that basically uncompensated care exists all over the country, and you cannot just pinpoint it in urban or in some rural areas. It is all over the country. There are big differences, though, in how those hospitals have been able to make up for the difference. If the hospital's predominant method of payment for the other patients is private insurance, they have been able to ease extra payments on the private patients.

And if the hospitals, however, do not have a large component of private patients and have large Medicaid patients, for example, they either have to look to the Federal Government and the Medicare payment as their deep pocket, which they have done, and you have helped them by the disproportionate share adjustment, the extra teaching adjustment, and so they have done almost as well on the totals as the other. The group of hospitals that are the most negatively affected are those hospitals that have large uncompensated care, not so large Medicare patient, and large Medicaid patient volume. And those hospitals are the ones where both the total margins and PPS margins are sinking.

So when you look at total margins, you find a very similar rate. So as I said in my testimony, I wish the numbers did not come out the way they did because I would have had a good answer. The numbers are more complicated and suggest that we are going to have to go back and look at them hard. And maybe one of the reasons we are seeing them is what you said.

Mr. CARDIN. Mr. Chairman, I would join Mr. Coyne in requesting that we look again at the definition of uncompensated care, and perhaps make it more sophisticated to reflect charitable care than the broader category that it currently does.

Mr. ALTMAN. Absolutely.

Chairman STARK. I would agree with the gentleman. As I say, I know it when I see it, but I would be hard-pressed to write the formula. Mr. McGrath.

Mr. MCGRATH. Thank you, Mr. Chairman. Dr. Altman, ProPAC indicates that in fiscal year 1990 and in the future about half of the hospitals are likely to lose money under Medicare. Are there certain characterizations that would differentiate those hospitals that are making money as opposed to those who are losing money?

Mr. ALTMAN. Yes, sir.

Mr. MCGRATH. What might those be?

Mr. ALTMAN. Obviously we cannot do it on a hospital by hospital basis, but as I pointed out in my testimony the hospitals that make money on Medicare—we have to distinguished between Medicare and totals.

Mr. MCGRATH. Right.

Mr. ALTMAN. Hospitals that make money on Medicare, interestingly enough, are often concentrated in your State, by the way. They tend to be large teaching hospitals. They tend to be urban hospitals. They tend to be rural referral centers. They are hospitals that receive significant amounts of disproportionate share payments. So those are the ones that make it, and those that do not are ones that do not hit any of those criteria. Now, again, as I pointed out to Mr. Cardin when you look at total margins, though, it exactly flips itself around and so on average total margins look similar between major groupings of hospitals.

Mr. McGrath. In other words—correct me if I am wrong or if I put words in your mouth—those hospitals that perhaps get a substantial IME payment make money on Medicare but perhaps lose money overall because of their uncompensated care, sicker patients, and whatever?

Mr. Altman. Right.

Mr. McGrath. Thank you. You also indicate in your testimony that per admission expenses continue to grow at roughly twice the general rate of inflation. Now how much of these increased costs result from, perhaps, smarter DRG coding and bookkeeping, and how much result from actually treating sicker patients or more resource intensive patients?

Mr. Altman. I think one of the most complicated, if not frustrating, aspects of trying to understand PPS is just that question. When PPS was first put in place, the best estimates of the actuaries and others who looked at it included some coding increases. But no one expected except maybe the most cynical of minds, including myself sometimes, that the rates of change would be as dramatic as they were, and they were very dramatic. We have spent a lot of analytical time trying to figure out ways of separating the two, and I would not claim that we have developed a perfect way of doing it.

But in our recommendations, our estimates for what we believe to be the increase in case mix that is the result of treating sicker patients and the increase which are due to sophisticated coding techniques. And it varies from year to year, and roughly is right around 50 percent. Our latest estimate suggests that about a third to 40 percent or so may be due to this sophisticated reporting, and the rest is due to sicker patients.

Mr. McGrath. I also notice in your testimony that you have not taken any position, and I recognize fully that we are not here for this purpose, to talk about the new capital regulation. But I am wondering on rather than on a detailed basis but on an overall philosophical basis, do you accept the premise on which the new capital regulations are based?

Mr. Altman. Well, as you pointed out, the Commission backed away from coming to a final set of conclusions because we wanted to see the regulations. I have just had time to review them briefly, and we have not had time to put them to any rigorous simulation. I will say this, though. I have been very impressed by the way the administration and HCFA has gone about putting these regulations together. I know we tried to do that several years ago, and by comparison this is a much more sophisticated approach. It tends to deal with problems that the former regulations did not deal with.

So I do come away with very much of a positive appreciation for the way the administration has dealt with this complex problem. In terms of the philosophy, I find myself personally in sympathy with the general approach that you want to create a set of neutral incentives that do not encourage capital formation beyond what would be really necessary for quality care. And we know that in the past, Medicare and other payers have developed payment systems that either advertently or inadvertently encourage certain spending, and capital was one of them. So philosophically, I am very sympathetic to the idea of treating operating costs and capital the same. And I think it is a question of whether the technique we use brings with it disadvantages that overcompensate for that philosophy.

Now I will say right off the bat, this is not necessarily a philosophy that may be shared by other members of ProPAC, but my own philosophy is that if we could develop a technique that meets some of the negative criticisms of the past but folds it in a way that creates equal set of incentives, I would support it.

Mr. McGRATH. I thank you for your testimony.

Chairman STARK. Mr. Moody.

Mr. MOODY. Thank you, Mr. Chairman. Dr. Altman, you have talked about margins for all sorts of hospitals. Do you have that broken down by types of hospitals, either total margins or PPS margins? For example, teaching hospitals or large urban hospitals, are their margins different and systematically so? Can you break that out a little bit for us?

Mr. ALTMAN. Yes. Well, I would be glad to send you detailed set of numbers. We have done these breakouts in more ways than I can remember. In general, as I pointed out, if you look at PPS margins, teaching hospitals, large disproportionate share urban hospitals, do very well. And hospitals that are nonteaching, nondisproportionate share do relatively poorly on the PPS. This completely flips around when you look at total margins.

Mr. MOODY. Right.

Mr. ALTMAN. The same hospitals that look like they are losing money on PPS come to be the best. And the ones that look like they are doing the best do the worst. And as I pointed out in a kind of rough justice which seems to have begun to prevail in the system, when you look at total margins there is a similarity in the level even though if you break them into subcomponents they go up or below the line.

Now I have the exact numbers which I will be glad to provide you or others if you want them.

Mr. MOODY. Thank you. Have you been able to breakout the impact of three things which tend to be drags on hospitals—Medicare, Medicaid, and uncompensated care? Medicare, hospitals will argue, does not cover full costs. Some say it does not even cover what they call full charges. Maybe you can explain to me what the difference between charges and costs is if Medicare and Medicaid do not cover charges. Medicaid falls even further below, far below that. In fact, Medicaid may cover only slightly above operating costs, variable costs, and would contribute nothing to capital at all. And then there is uncompensated care. Those three items, obviously, are the three big drags on the system. Do you break them out by the relative magnitude either in an aggregate sense or by types of hospitals?

Mr. ALTMAN. Well, let me basically first define them. Charges are what hospitals put as their price. And aside from a few regulated States, let us just say that——

Mr. MOODY. It is their sticker price.

Mr. ALTMAN [continuing]. It allows a fair amount of latitude in terms of the hospital what they choose to put down. They can basically almost put any number they can come up with. Costs is a technical term that has been developed by accountants and related people for the Medicare cost reports that include all items divided by the number of patients they treat and then all kind of adjustments here and there.

Medicare has its definition of average costs. There is a different definition for others. There is a false sense of precision about costs as far as I am concerned because what you included in the numerator and what you include in the denominator has a big impact on what comes out.

Mr. Moody. Right.

Mr. Altman. And as was pointed out about the definition of charity care, you can wind up with quite different measures of costs depending on how you measure it. It is fair to say that at least with respect to Medicaid in many States, they do not pay average costs. They pay less.

Mr. Moody. They do not pay average variable costs or average total costs?

Mr. Altman. Average total costs. And I think your point about using the term variable costs is a very good one. And we have never measured that. It is only economists that even use the term. But it is an issue that——

Mr. Moody. But it is essential for clear thinking.

Mr. Altman. Well, you and I believe that. It is the rest of the world that has trouble understanding that. I think it is a very important concept. Many States faced with budget constraints have been forced to limit their Medicaid payments below what the hospitals define as their average costs. But the question that you ask is a good one, and it is one that I have been asking. Are these patients, and are these States, generating costs which exceed the variable costs?

Mr. Moody. Right.

Mr. Altman. Or the marginal costs of treating them? And I do not know the answer to that. My sense is that in most cases the answer is yes. That Medicaid is paying more than the marginal costs or variable costs but not the average, and which generates the need for these hospitals to find extra payments from others to make up the average. In terms of the fact that Medicare is not paying hospitals their average costs, it depends again on which hospitals you are talking about. On average, it is true that Medicare now is paying somewhat less than the average cost throughout the United States. It varies a lot depending on the hospital, as we pointed out. For some hospitals it is significantly more than its average cost and some are less.

Mr. Moody. Right. Well, as we come to grips with this issue of capital costs, any solution, any intelligent solution is going to have to be based on data as to what our capital costs are relative to variable costs, fixed costs relative to variable costs. And if we do not even know the breakout between variable and fixed costs, it seems like we are always going to be operating on a guess basis. And why is the data so poor? Why are we unable to break out that data? I mean that is such a fundamental cost concept in every other field in any cost accounting sense.

Mr. Altman. Well, as you know, there is a fair amount of joint costs associated with this industry.

Mr. MOODY. Sure.

Mr. ALTMAN. And once you have joint costs, it becomes very difficult to apportion——

Mr. MOODY. To allocate them is very difficult, but to know what they are is something else.

Mr. ALTMAN. That is right. It is very difficult to allocate them. And as a result, any allocation method you come up with is arbitrary.

Mr. MOODY. Right.

Mr. ALTMAN. Now there have been studies that have attempted to do this.

Mr. MOODY. Econometric studies or micro-cross-sectional studies? Econometric studies that are sort of——

Mr. ALTMAN. There have been econometric studies that have attempted to do that, yes. But it is not routinely done, say, through the Medicare cost reports. I do not know if the AHA? Have you guys—do you do that, Paul?

Mr. RETTIG. Sorry, I did not——

Mr. ALTMAN. Variable costs?

Mr. MOODY. Fixed versus variable. You do not. No.

Mr. ALTMAN. It is a good research project which I think some university would be more than——

Mr. MOODY. You know the hospital really can be conceived as a multiproduct firm.

Mr. ALTMAN. That is right.

Mr. MOODY. And any multiproduct firm that is in a profit maximizing mode of behavior, which they are supposed to be if they are in the private sector, has to do these kind of calculations. It seems to me incredible that here we have such a huge public sector where this basic maximizing or optimizing behavioral parameter; namely, fixed versus variable costs, has never been broken out and analyzed.

Mr. ALTMAN. Well, I agree with that. Now I am not saying that individual hospitals do not have in their bottom drawer, at least good, well-managed hospitals do not have in their bottom drawer a good sense of what variable costs and fixed costs are all about. And the reason why I say they probably do is they are always engaged in these negotiations now with PPOs and managed care in terms of discounts, and I would think, well, I know that they have a good sense of what they are prepared to allow them in terms of price based on some estimate of what the variable cost is.

Mr. MOODY. Right. But the public policymakers have never been given this information in any systematic way.

Mr. ALTMAN. That is right.

Mr. MOODY. Should they be?

Mr. ALTMAN. I think they should, and I do think it is a big issue when it comes to Medicaid as well as Medicare but particularly Medicaid.

Mr. MOODY. Particularly Medicaid. I mean you could argue that Medicaid certainly should be required to pay variable costs, but we do not know that it is even doing that. We do not know for sure. We have a hunch. We have a horseback sense it is.

Mr. ALTMAN. Well, we get down to an issue, I think that others, particularly private payers would take issue with that because they feel that they lack the financial leverage that Government has, and therefore they get caught with the fact that they not only pay average costs but they are going to pay average costs plus to make up for the fact that Medicaid and Medicare are sort of extracting these deep discounts. I think it points to a basic issue, and that is in our system with multiple payers paying different rates where the rates are based more on ability to pay than true cost, it becomes a constant battle of relative power.

Mr. **MOODY**. Right. It is something like railroad pricing. You know you had freight.

Mr. **ALTMAN**. Exactly.

Mr. **MOODY**. How much should the freight pay toward the rails and how much should the passenger pay toward the rails? And if your passenger is strictly inframarginal then expect the entire freight to pay the entire roadbed costs. But if the passenger becomes a major factor, then you need to find an allocating formula. But what was interesting during the railroad's demise is they were always arguing to get rid of passenger because they said they did not pay their full average cost, ATC. But once they got rid of passengers, suddenly their fixed costs on their freight jumped up because now they had to allocate the entire fixed cost to the freight side of the ledger. It is a similar problem.

Mr. **ALTMAN**. I think it is absolutely a similar problem.

Mr. **MOODY**. Thanks very much for your comments.

Chairman **STARK**. Mr. Levin.

Mr. **LEVIN**. Thank you. Stuart, let me just say that I think Dr. ProPAC is a better title. Let me ask you about your recommendation on IME. On page 8 of your testimony you discuss operating margins, and you indicate that the overall financial performance of the teaching hospitals is poor relative to other hospitals. You then suggest a reduction in the IME. Now why are you proposing a reduction given these facts?

Mr. **ALTMAN**. Well, what has happened, while I am personally very sympathetic to what has happened because I do believe that this committee and the Congress is acting in a broader understanding of the health care delivery system than just worrying about Medicare. So I personally am very sympathetic to the kinds of adjustments that have been made and the fact that we should no longer simply look at Medicare costs and Medicare payments.

However, it is also true that some of the money that is not going to teaching hospitals that do not have the ability to pass these extra costs along are hurting so that the average is misleading because there are hospitals that are seeing substantially lower Medicare numbers than even the average. And so our recommendation is very clear. We want the amount to go back to those hospitals. I would not recommend that we just pull the money out and save it. It allows the Medicare program to average a little better. It also puts some restrictions on the Medicare payment for essentially non-Medicare costs. That is what, while as I said, I am personally, and the Commission is sympathetic to breaking the bounds of dollar for dollar. There should be a limit of using the Medicare program to solve all the ills of our health care financing system because after all the Medicare trust fund does not come from everybody in proportion to their income. It is not the most progressive taxing system.

So we try to balance that out and recognize a higher payment. Put some limit on it. Put some constraint on these hospitals and I will have to admit it is an arbitrary number. It just says do a little, cut it back, but do not cut it back very seriously. Now I mean we gave you our recommendation. Some would recommend that it go all the way back to 4.2 or even 3.2. Others would suggest that it stay at 7.7. But our best judgment, and it was a close call, I might add, was to make a modest reduction.

Mr. LEVIN. Of course, it might make sense if Medicare is overpaying, is carrying too much of the burden, to make the reduction of it contingent on it being picked up somewhere else. And the problem with accommodating to the externalities, reducing it by 0.7 of a percent, is that there is no assurance that for some of these hospitals under pressure that there will be a replacement anywhere else.

Mr. ALTMAN. Well, that is fair. It is also—I have to say this since I think there needs to be said the other side of the coin. And it has been said to us many times that it is not clear that these hospitals are the most efficient in our system. And there is an alternative to finding another payer. And that is to get the costs down. Now, again, I think if we were to drop all the way from 7.7 to 4.2 or 2.2, you are talking about a very substantial drop which I do not think could be made up by either other payers or costs which would not impact on quality.

And again, it was our judgment that a modest reduction could lead to a set of incentives which would perhaps lower costs, not for those hospitals to seek other payers. I think this game of looking for other payers is very counterproductive. That is not why you passed PPS, I hope. You passed it to introduce a set of incentives that would lower expenses rather than just finding ways for other people in the system to pay for Medicare patients. And as I pointed out in my testimony, one of the frustrations of PPS is that asking Medicare alone to bear the burden of putting in a system to lower costs has had only limited success.

Mr. LEVIN. Well, that raises a point—let me just quickly express to you what I think is the real danger. We are now arguing whether we should try to build on the present system of health care in this country or to dramatically revise it. I think there is a real danger that we are going to, in the name of building on the present, and there is a good argument for it, instead just limp along. You and this committee, in the subcommittee, have been talking for a number of years now about what we do with disproportionate share.

Mr. ALTMAN. Right.

Mr. LEVIN. Last year you said you just could not make any sense of it. And we rather formally asked you, or was it the year before, and I say this to you as your being a person who cares as much about this as anybody else or more, but you have had trouble grabbing ahold of it, understandably so. And so what we end up with is what you called rough justice. Somehow all of the disparities, all of the minuses add up to some kind of a rough plus over all. But when I was home last weekend first talking to people in an unemployment comp line and then at town meetings, I was struck by how for a lot of people in this country, rough justice is more rough than it is justice.

And there are just deep feelings about the lack of adequate health care. And that there really are thousands and tens of thousands of people who are scrambling on the edges with no health care or with very inadequate health care. And we are just kind of limping along. Let me give you, for example, one possible interpretation of these inconsistencies. This is just an impression, and I like to say it because I think this subcommittee is so unprovincial, and what is true for me is true for, I think, everybody on this subcommittee. I am talking about hospitals that are not in my district basically. But this is so interwoven, perhaps they all affect each other. That maybe what is happening is something like this. I just scribbled it out.

That some of the hospitals, the teaching hospitals, are making money off of Medicare, if you want to call it that, partly because of IME, but also because some of them are really more efficient. Some of it is because of volume. Some of these are large institutions. Some of them are first-rate institutions that once were the gilded lily institutions in the metropolitan area like Henry Ford. It bears his name because you almost had to be Henry Ford to be treated there. But now are in the trenches of health care and hospital care in urban centers in this county in the metropolitan area. And I think there is an immense amount of efficiency there, part of it comes from volume.

But they also have just an immense amount of uncompensated care. You know they are on the front lines for providing AIDS care. They are on the battle lines dealing with the problems associated with drug addiction. They are on the battle lines of people who come in without any insurance at all. And then how do we put together this fact with the statistic in there that the percentage of the uncompensated care that they are providing is going down? I think the answer is that in some of these cases, they are just stuffed to the gills in terms of the burden that they are carrying. I am just throwing this out as a possible explanation.

They cannot really do, I mean there is a diminishing amount of uncompensated care proportionately that they can provide. And so what they are doing is forcing other institutions to pick up the slack, but that is being done on a very haphazard basis. And what concerns me is the response to Mr. Coyne's question which we have been asking for a number of years. I am not sure we are any closer. And if we are going to "build on the present system" in quotes instead of totally redoing it, I think we better quickly get some better information and some notions as to where we are going. Because while when you put this all on the scales, it may statistically seem more or less to balance out, it is not balancing out for tens of thousands of people. And I do not know where we go.

There is too much of a burden on the Medicare system arguably. But that is because it is compensating for a lack of an answer anywhere else. So, I mean what do you say to us? Are we going to be in the same situation 2, 3 years from now as we are today in terms of knowing where we go with IME, with disproportionate share, with uncompensated care? Are we going to continue to have a system where tens of thousands of people literally are falling between the cracks, and it is every worse than that because there is so little preventive care in those cases that we are seeing the cost for society go up in terms of the provision of emergency care, infant mortality, untreated drug addiction, et cetera.

Mr. Altman. Let me try to see if I can disentangle a number of these. First, let me say that I could not agree more with you. This is the major problem in our health care system. Now my definition of rough justice was aimed at classes of hospitals. It was not aimed at people. My sense is exactly yours personally, and that is that it is a shame that a country as rich as ours should have 37 if not 50 million Americans that have no health insurance or very poor health insurance. And we are being forced to use an inappropriate technique to compensate for the fact that we have millions of Americans that cannot pay their bills. It is inappropriate at several levels.

It is inappropriate because of where the money comes from. It uses a mechanism that was never designed to do that. Now that does not mean we should not try. Now the frustration that you have and that I have is that because we are using an inappropriate mechanism because it is the only one we have, it really is not aimed as accurately as we would like. We have a lot more information this year than we had last year and the year before on this issue, thanks in part to you because you have asked us to do it and we have. But it does not present a picture that leads to a clearly articulated strategy.

For example, we know if you just use a teaching adjustment, it winds up benefiting a small number of hospitals that provide very little uncompensated care. And if I were to present you with the balance sheet, you would say I do not want my money going to them because they are not doing what you said Henry Ford and others are doing. But we use this rough justice of the IME to compensate. The second issue is the definition of uncompensated care. When we move from disproportionate share to uncompensated care, we get a very different set of hospitals that come on the radar screen, and some of them are not being reimbursed well at all by the PPS system. That is one of the problems in rural areas.

So I agree with you wholeheartedly. We should not simply build on the current system in all aspects. We need to develop on the demand side. If we are going to have national health insurance so that everybody brought a chit or a capacity to pay the bill, then you would have a much better payment system, more reflective of need. I think to the extent that we develop a payment system, we need to better link in the different payers between Medicare and Medicaid and private insurance and discounting policies and stuff like that. So, yes, there is a frustration that you have and that we have. It is not because we do not have more data. As a matter of fact, the more data we get now, the less it leads us to a clear policy.

I could present you with all kinds of different correlations and permutations of the relationship between Medicare payments, disproportionate share, teaching adjustment, uncompensated care. And the best I can tell you is in a rough way, IME and disproportionate share are doing the job you want it to do, but it is far from a perfect system. And yes, we are trying to develop a better one to give you a recommendation on how to modify the IME to better do what you say you want, how to modify the disproportionate share adjustment. But it is not easy because every time we have come up with a modification, and we have been trying to do that, some hospitals come out better, and other hospitals come out worse, and the net does not seem to be all that good. So I think the end of this is if we were to develop a payment system that had everybody insured so that there was not uncompensated care, we would be much more ahead of the game than trying to do it backwards, and that is what we are doing. We are doing it backwards. And any attempt to do it backwards is never going to be perfect.

[The following was subsequently received:]

Prospective Payment Assessment Commission

300 7th Street, S.W.
Suite 301B
Washington, D.C.
20024
Tel (202) 401-8986
Fax (202) 401-8739

March 21, 1991

The Honorable Sander M. Levin
House Ways and Means Committee
323 Cannon House Office Building
Washington, DC 20515-2217

Dear Sandy:

At the recent Ways and Means Health Subcommittee hearing you asked me to explain why I believed that improvements were needed in the Medicare teaching and disproportionate share adjustments. I would like to provide you with some of the information ProPAC has developed that led me to this conclusion.

As ProPAC and others have shown, PPS payments to teaching and disproportionate share hospitals significantly exceed the extra costs those hospitals bear in treating Medicare patients. Thus, these hospitals have higher PPS margins than other hospitals. The overall financial condition of some teaching and DSH hospitals, however, is not as good as non-teaching, non-DSH hospitals. At the same time, other teaching and DSH hospitals are doing quite well overall. This is especially true for hospitals in urban areas with less than 1 million population.

There are three important aspects to the Commission's recommendation. First, it would result in a modest decrease in teaching payments. We believe this is necessary to bring the relationship between Medicare payments and costs more in line with other hospitals. Second, it would continue Medicare support for the special needs of teaching and DSH hospitals. I believe the Federal government should support these needs. Overtime, however, funding sources in addition to Medicare should be identified. Third, our recommendation points out that the current distribution of teaching and DSH payments support many hospitals that provide little uncompensated care and that are in good financial condition. As I indicated, we must better target the spending to those hospitals most in need.

Unfortunately, the wide diversity in location, type of patients treated, and other factors makes this task much more complicated than we initially believed. In addition, we believe it is important to include the impact of medicaid payments in our analysis which is continuing.

I believe our recommendation strikes an appropriate balance between the responsibilities of the Medicare program and the broader responsibilities of the Federal government regarding the support of this important group of hospitals. It also will subsequently lead to better use of the Medicare program's resources.

The attachment to this letter presents ProPAC's findings in more detail.

If you have additional questions or suggestions, I would be pleased to discuss them with you. As usual, it was a pleasure to appear before the Subcommittee. I am always challenged by your thoughtful and probing questions.

Sincerely,

Stuart H. Altman, Ph.D.
Chairman

ATTACHMENT

TEACHING AND DISPROPORTIONATE SHARE HOSPITAL FINDINGS

Hospitals which are both teaching (IME) and disproportionate share (DSH) have the highest PPS margins and the lowest total margins (Figure 1). Hospitals that are teaching but not DSH have the second best PPS margins but the highest total margins. This group of teaching hospitals is in the best overall financial condition of all the groups.

Only DSH hospitals in large urban core areas have total margins which are significantly less than average (Figure 2). DSH hospitals in other urban core areas, however, have the second highest total margins of all groups.

The largest share of DSH payments go to hospitals in the lowest margins groups (Figure 3). The 40 percent of hospitals with the highest margins, nevertheless, received 24 percent of all DSH payments in PPS5. OBRA 90 increased DSH payments overall. It also resulted in a relative increase in DSH payments to hospitals with the highest margins and a relative decrease for hospitals with the lowest margins.

Figure 4 shows that the uncompensated care load is spread across all types of hospitals. Major teaching hospitals have uncompensated care costs which are 4.9 percent of total costs while non-teaching hospitals have 4.7 percent. The difference between DSH and non-DSH hospitals is somewhat wider.

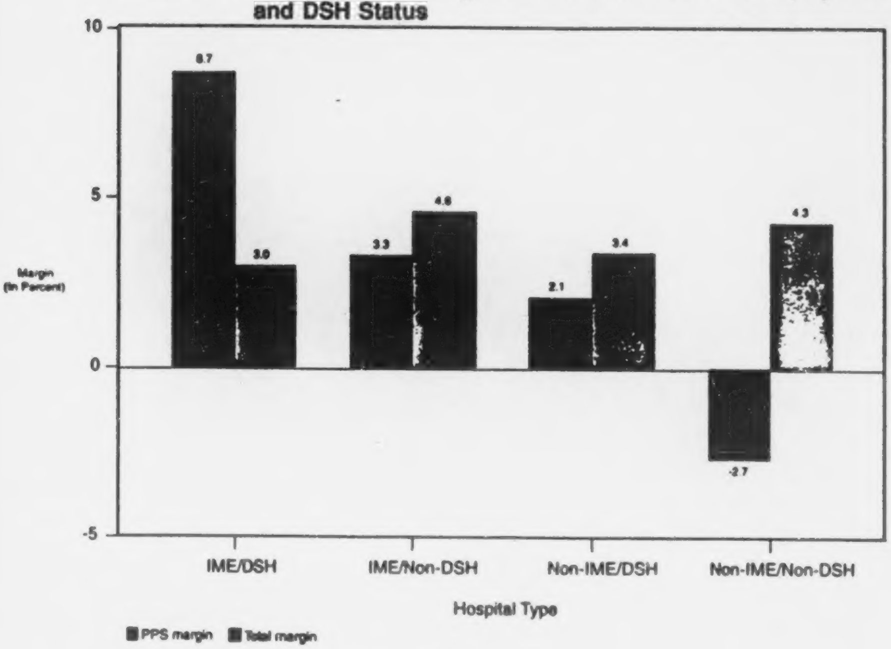
The portion of uncompensated care costs borne by major teaching hospitals has declined from 23 percent in 1980 to 18 percent in 1989, while the portion for non-teaching hospitals has increased from 35 percent to 44 percent (Figure 5).

For urban hospitals with the lowest 10 percent of total margins, uncompensated care costs were 5.6 percent of total costs. Urban hospitals with the top 10 percent of margins also had a significant uncompensated care load of 4.5 percent of total costs. As you can see, while there is a relationship between low total margin and uncompensated care load, it is not strong.

The bottom 10 percent of teaching hospitals furnish only 0.1 percent of all uncompensated care, yet they receive 9 percent of teaching payments. The top 10 percent of hospitals furnish 27 percent of all uncompensated care and also receive about 9 percent of teaching payments (Figure 7 and 8).

There is a slightly better relationship between DSH payments and uncompensated care costs. Again, however, 10 percent of hospitals provide only 0.1 percent of all uncompensated care, yet they receive 7.5 percent of all DSH payments (Figure 8).

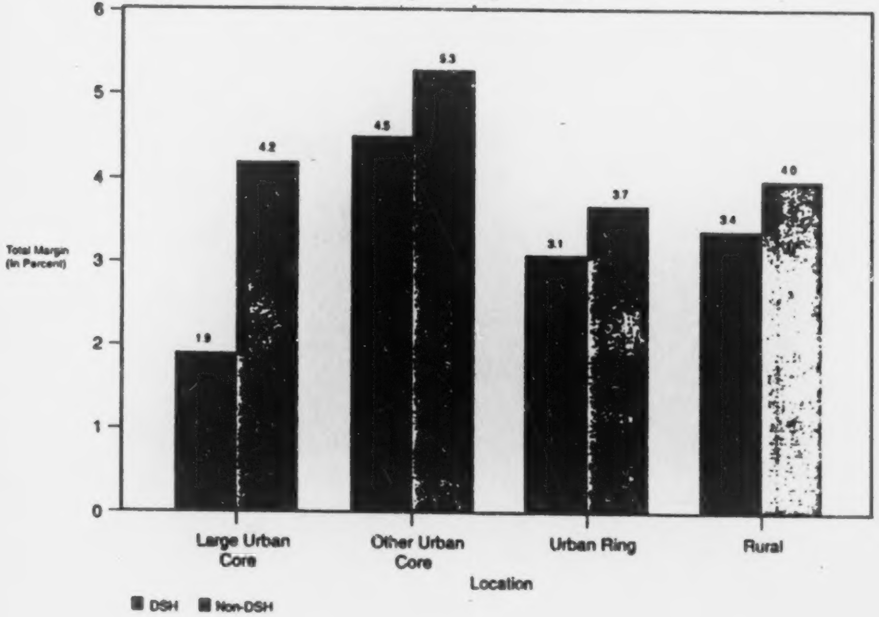
FIGURE 1: PPS and Total Margins in the Fifth Year of PPS, by IME and DSH Status



Note: Indirect medical education (IME); disproportionate share (DSH).

SOURCE: Medicare Cost Report data from the Health Care Financing Administration.

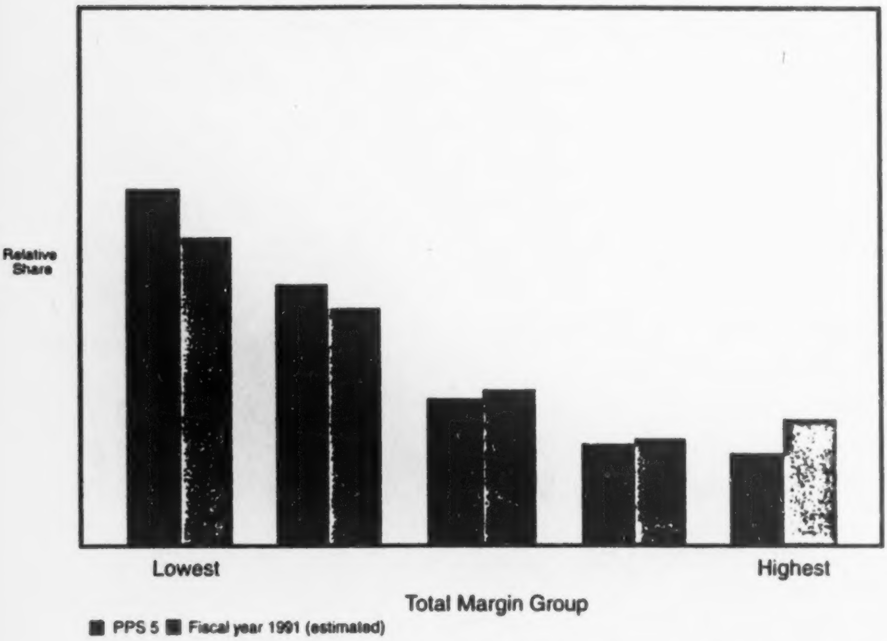
FIGURE 2: Total Margins in the Fifth Year of PPS for DSH and Non-DSH Hospitals by Location



Note: Indirect medical education (IME); disproportionate share (DSH).

SOURCE: Medicare Cost Report data from the Health Care Financing Administration.

FIGURE 3: Relative Share of DSH Payments in PPS 5 and Estimated for Fiscal Year 1991



Note: Total margins are calculated excluding indirect medical education (IME) and disproportionate share (DSH) payments.

SOURCE: Medicare Cost Report data and ProPAC PPS payment model.

FIGURE 4: 1984-89 UNCOMPENSATED CARE COSTS AS A PERCENT OF TOTAL COSTS, BY PPS HOSPITAL GROUP

Hospital Group	Without Offset for Government Subsidies	Amount of Government Subsidies	With Offset for Government Subsidies
All hospitals	6.1%	1.4%	4.7%
Major teaching	10.1	5.2	4.9
Other teaching	5.1	0.3	4.8
Non-teaching	5.0	0.5	4.5
Disproportionate share:			
Large urban	8.2	3.2	5.0
Other urban	7.7	2.0	5.7
Rural	7.5	0.7	6.8
Non-disproportionate share	4.4	0.3	4.1
Urban central city*	7.1	2.3	4.8
Urban ring*	4.6	0.4	4.2
Voluntary	4.7	0.1	4.6
Proprietary	4.3	**	4.3
Urban government	14.4	8.7	5.7
Rural government	6.7	1.9	4.8

* Nation's 100 largest cities only.

** Less than .05 percent.

FIGURE 5: PROPORTION OF UNCOMPENSATED CARE COSTS WITH GOVERNMENT SUBSIDY OFFSET, BY PPS HOSPITAL GROUP

Hospital Group	1980	1984	1988	1989
Urban	85%	87%	86%	86%
Rural	15	13	14	14
Urban central city*	71	71	69	67
Urban ring*	29	29	31	31
Major teaching	23	21	19	18
Other teaching	39	37	38	38
Non-teaching	38	42	43	44
Voluntary	69	71	72	75
Proprietary	4	6	10	9
Urban government	19	17	14	12
Rural government	8	6	4	4

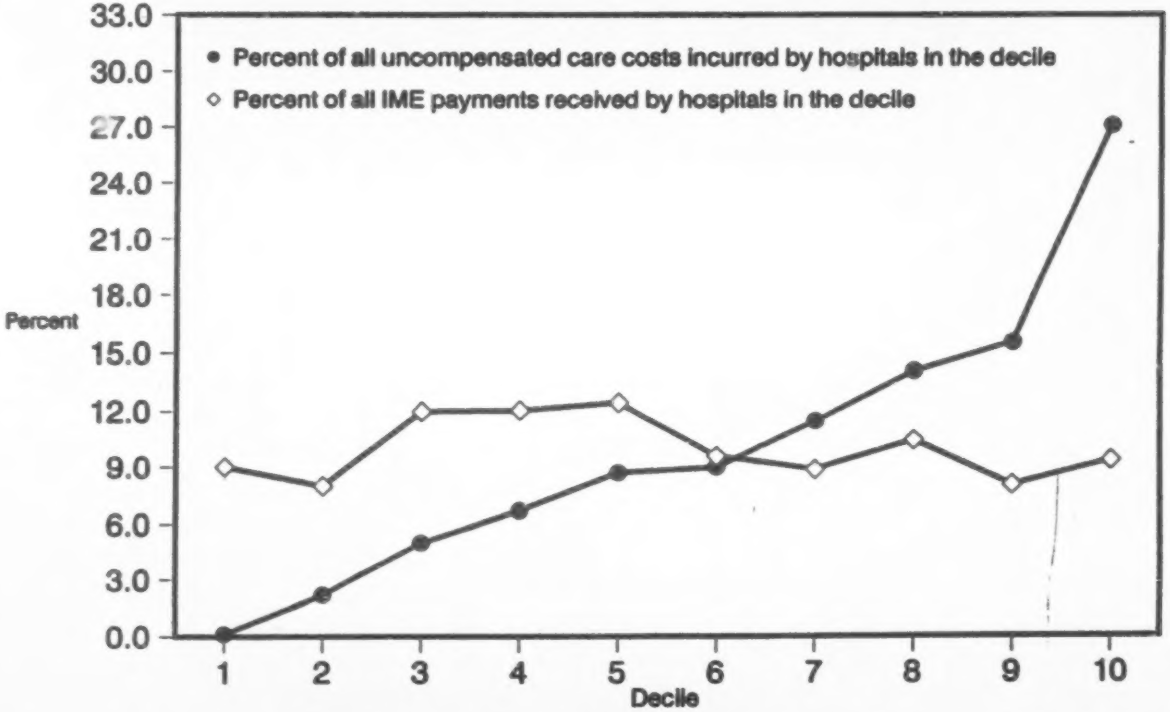
* Nations 100 largest cities only.

FIGURE 6: RELATIONSHIP BETWEEN UNCOMPENSATED CARE COSTS WITH GOVERNMENT SUBSIDY OFFSET AND TOTAL HOSPITAL MARGINS, PPS 5

	Distribution by Total Margin			
Measurement	Bottom 10 Percent	Bottom 25 Percent	Top 25 Percent	Top 10 Percent
Urban hospitals				
Average total margin	-14.5%	7.7%	10.9%	14.6%
Uncompensated care costs as percent of total costs	5.6	5.2	4.6	4.5
Rural hospitals				
Average total margin	-20.3	-11.7	11.0	15.1
Uncompensated care costs as percent of total costs	4.2	4.4	3.9	3.8

FIGURE 7

Relationship Between Hospital Uncompensated Care Costs With Government Subsidy Offset and PPS IME Payments, PPS 5



Note: Decile groups defined on the basis of a ranking of individual hospitals' uncompensated care costs with government subsidy offset as a percent of total hospital costs.

FIGURE 8

Relationship Between Uncompensated Care Costs With Government Subsidy Offset and PPS Indirect Medical Education and Disproportionate Share Hospital payments, PPS8

Percent-of-Total Measurement*	Distribution by Uncompensated Care Cost Rate									
	First Decile	Second Decile	Third Decile	Fourth Decile	Fifth Decile	Sixth Decile	Seventh Decile	Eighth Decile	Ninth Decile	Tenth Decile
Uncompensated care costs with subsidy offset	0.1%	2.2%	5.0%	6.7%	8.7%	9.0%	11.5%	14.1%	15.0%	27.1%
IME payments	9.0	8.0	12.0	12.1	12.5	9.6	8.9	10.5	8.1	8.4
DSH payments	7.5	4.7	8.1	10.5	7.9	7.7	10.3	11.1	11.9	20.3
IME and DSH payments	8.6	7.1	11.0	11.7	11.3	9.1	9.2	10.7	8.1	12.3

*The numbers shown are the amounts for hospitals in each decile as a percentage of the amount for all hospitals.

Relationship Between Uncompensated Care Costs Without Government Subsidy Offset and PPS Indirect Medical Education and Disproportionate Share Hospital payments, PPS5

Percent-of-Total Measurement*	Distribution by Uncompensated Care Cost Rate									
	First Decile	Second Decile	Third Decile	Fourth Decile	Fifth Decile	Sixth Decile	Seventh Decile	Eighth Decile	Ninth Decile	Tenth Decile
Uncompensated care costs without subsidy offset	1.1%	3.8%	4.9%	6.5%	7.4%	8.4%	10.0%	12.3%	13.1%	31.5%
IME payments	4.9	12.6	11.5	11.3	11.7	8.9	8.1	11.2	6.3	13.6
DSH payments	3.4	7.0	10.0	8.5	8.7	9.5	8.2	11.3	9.9	23.6
IME and DSH payments	4.5	11.1	11.1	10.5	10.9	9.1	8.1	11.2	7.3	16.2

*The numbers shown are the amounts for hospitals in each decile as a percentage of the amount for all hospitals.

Chairman STARK. Mrs. Johnson.

Mrs. JOHNSON. Thank you, Mr. Chairman. I am sorry to have missed some of the inquiry, but I very much enjoyed your testimony, as usual very informative. Let me just ask you a specific question. You talk about a recommendation that you are considering in regard to modifications in the wage index reflecting variations in the mix of occupations employed. Sometimes the mix of occupations reflects a hospital of specialization, which serves more of certain kinds of patients. If you, in a sense, wring out of your wage calculations your wage index or base for that hospital, the mix that is associated with the unique services that hospital provides, then will you not disadvantage that hospital?

Mr. ALTMAN. I do not think so, Mrs. Johnson. My sense——

Chairman STARK. Would the gentleman and the gentlelady yield at that point only because I have some confusion over that same part of your testimony, and in responding to the gentlelady, could you kind of explain to me in more detail——

Mr. ALTMAN. I will try.

Chairman STARK [continuing]. What kind of wages you would be changing here? I am a little confused.

Mrs. JOHNSON. Perhaps I misunderstood you because I was not here from the beginning.

Chairman STARK. I am glad you asked the question.

Mr. ALTMAN. Listen, it confused me. That is why I stopped reading what I wrote. First, to the extent that a hospital specializes and treats a particular kind of patient, that should be reflected in their DRG weight. So the extent that they need a more specialized group of personnel, higher skills and wages, that is what the DRG weights are supposed to reflect. And so a two is more than a one weight, and therefore the hospital will receive the higher payment. Now when we created the DRG system, we said after we have accounted for the fact that hospitals will treat sicker patients, we need to reflect the fact that in some parts of the United States wages are generally higher for everything, for every level of occupation. And, therefore, we should build in a wage index that reflects that, and that seemed appropriate.

Now to the extent that the wage index does not only measure differences in wages, but measures differences in salaries, you build into the wage index both the fact that everybody gets more money, plus the fact that certain areas may choose to use a richer mix of workers to do the same thing that another area is doing, and that is what we consider to be an inappropriate addon to the wage index for higher occupational mix because that is under the control of the hospital.

Mrs. JOHNSON. I hear what you are saying, and perhaps it is adequate. It seems to me that it is risky. The DRG weight for a hospital that specializes, for example, in a lot of orthopedic work and a lot of cardiology work and maybe some other thing, would certainly reflect the greater intensity of physician input, but would it necessarily reflect the greater lab use and that kind of auxiliary thing?

Mr. ALTMAN. It is the other way around. It does not, it is based entirely on the higher cost to the hospital. To the extent that the physician is a nonhospital expense item, it is not there. It is designed to capture more lab tests, higher wages to workers. That is what it is all about.

Mrs. **Johnson**. I see.

Mr. **Altman**. That is what it was designed to do.

Mrs. **Johnson**. OK. Thank you. That clarifies it for me.

Mr. **Altman**. Now you could—by the way, we gave you our recommendation based on what the law says we should do. Now the problem of leaving it in, it goes exactly in the opposite direction, say, than the capital adjustment and others. It tends to—if you leave it in—reflect higher costs that are not associated with higher wages.

Mrs. **Johnson**. OK. Thank you.

Chairman **Stark**. Mr. Gradison.

Mr. **Gradison**. Thank you, Mr. Chairman. First off, I regret not being here for your presentation of your testimony, but thanks to you making a copy available last night, I have read it. I was at a budget hearing. I want to comment on the matter of the payment system which you were just talking about. I am not sure that there is any disagreement between us. I think if there were a method to pay for everybody that it would reduce the differences among hospitals in terms of their financial situation, but it certainly would not eliminate it because the assurance that you are going to get paid does not assure that you are going to get paid adequately. There still will be an incentive for payers to get the best deal they can, whether it is a public payer like Medicare or Medicaid or an employer-sponsored plan or an insured plan.

And if those groups strike a tough enough bargain, even though the hospital gets paid for everybody they take care of, they still will not be able to keep their doors open.

Mr. **Altman**. Absolutely.

Mr. **Gradison**. Fair enough?

Mr. **Altman**. Yes.

Mr. **Gradison**. OK. I have just two specific things. First of all, while this may not be possible, I hope you will see if there is any way you can accelerate your report to us on capital. You may well need the time that you indicated in your statement. I understand that. If that is how it is, that is how it is. But we certainly, in my view, will not want to act on it until we do hear from you, and the quicker the better.

One thing that puzzles me about the capital proposal, and I am no expert on it yet, is that it indicates that there will be some low cost, low capital costs hospitals that will be losers, and some high capital costs hospitals that will be winners. Now that may be something that cannot be avoided just as you were talking about classes of hospitals and the need to deal with averages. Nonetheless, I find that troublesome when we are trying to put in a new system, and when we are trying to deal fairly with those who have not indulged in the arms game or whatever. I am only repeating what is in the HCFA information on this, and I hope you will take a special look at that.

The second thing, and I do not want to suggest that this should take long, because you have already explained it in your statement, but could you pinpoint as briefly as you can for us why you disagree with the administration's recommendation on IME? I mean you have come in with a suggestion for a very modest reduction. They have come in with a recommendation for a very major reduction. I presume you are working from the same data. Why do you come to a different conclusion?

Mr. ALTMAN. Well, I think it goes back to Congressman Levin's discussion.

Mr. GRADISON. OK. So it is related to the——

Mr. ALTMAN. It is very much related.

Mr. GRADISON. It is a proxy for uncompensated care and treatment of low income people and all that.

Mr. ALTMAN. Absolutely.

Mr. GRADISON. OK.

Mr. ALTMAN. It has nothing to do with the data.

Mr. GRADISON. Super. Well, that is consistent with what the administration has said. Secretary Sullivan appeared before us in the Budget Committee, and on that same question basically he took the position that, viewed separately from everything else, the payment was excessive for IME within the context of Medicare. Fine. That is the other point of view; right?

Mr. ALTMAN. Now the one technical difference. For the first time we have now changed the way we run those regressions and felt that it was inappropriate to include disproportionate share even though they received it because you basically have given that for different purposes, and then to penalize the hospital, you are like giving with one hand and taking back with the other. So we said let us leave the disproportionate share out, and that raises the technical measure from what, 3.2 to 4.5, 4.2?

Dr. YOUNG. 4.2.

Mr. ALTMAN. Yes. From 2.1 to 4.2. Now or even higher difference, bigger difference. So that is just a technical change. But the big issue is one that we talked about an that is whether you want to see that much of a reduction in payment to hospitals that are being asked to sort of be on the front line of AIDS and related problems.

Mr. GRADISON. On this question of DRG creep and acuity, I assume that one reason hospitals have more acute cases is that an increasing number of activities and procedures are being done outside the hospital setting for the less acute conditions. But would you speculate with us as to why there appears to be an increase in acuity within a DRG? I mean are people with coronaries that come to hospitals sicker now than people who came to hospitals with coronaries 5 years ago?

Mr. ALTMAN. I think I will turn it over to Dr. Young.

Mr. GRADISON. Thank you.

Dr. YOUNG. The amount that is within the DRG has progressively diminished over the PPS years. So this year it is the smallest that it has ever been. That reflects the fact, in part, that the structure of the DRGs has continually improved and cases are being better assigned reflecting their condition.

The second reason, though, for within DRG complexity is the capability to do more services to people. They may not be any sicker as they walk in the door, but we have capabilities for diagnostic imaging, cardiac catheterization, invasive surgeries, that are far more complex. So that their total resource requirements make them more complex, not the inherent nature of their disease.

Mr. GRADISON. Very good. I understand now. Thanks a lot.

Chairman STARK. Mr. Pickle.

Mr. PICKLE. Well, Mr. Chairman, you are kind to recognize me, and I will not impose on the committee. I would like to ask Dr. Altman something about the rural hospital program. I understand from your testimony that you are going to be making recommendations on rural hospitals by mid-1991. And you also go on to state that these policy changes ought to be considered with regard to specific problems of a quote "subset" of rural hospitals rather than the broad range. I do not understand what you mean by that. Can you tell me what you have in mind for rural hospitals?

Mr. ALTMAN. Well, up until now the changes that have been recommended, and many of them have been passed to give rural hospitals larger update factors to equalize the standardized amounts, have been across the board. And they seemed reasonable. We have never had a chance to factor them in completely because they are just coming on line, many of them. Now the feeling that we have, looking at the preliminary analysis, that if you look at the averages now, rural hospitals tend to look a lot like urban hospitals. They are now appreciable better or worse relative to what they are receiving from PPS. But those averages hide some very special problems, particularly for rural hospitals. And even the use of the term "sole community hospital" may not be adequate. And it has to do with the discussion that we have been hearing, isolated areas, that travel distances are very far, that have very few inpatients but need the few they have to keep the outpatient unit going.

It is at that point that you really do need a very finely aimed rifle shot as opposed to a larger policy. Now I am not sure we are there yet, and we are waiting to see whether the averages are doing what we hoped they would do. But at that point, I think it would be a mistake to use aggregate PPS changes to deal with their problems, and you may at that point need very specific policies.

Mr. PICKLE. Now, we have pronounced the Congress' policy of closing this disparity and making specific adjustments in reimbursements. Are you saying that your studies might indicate some rural hospitals should receive a higher reimbursement than others?

Dr. YOUNG. It could include a number of things. For example, there is a provision for a volume adjustment. We may recommend that that volume adjustment should be automatic for hospitals lower than 50 beds but not for others, or lower than 25 beds. I do not know if we would find that, but that is a kind of an example. We have defined and HCFA has defined previously sole community hospitals based primarily on mileage and some weather conditions. It may be that you can define hospitals and need of access by looking at population density, and therefore you would define a different set of hospitals based on a population density in an area. It is that kind of targeted analysis and the possibility of recommendations that we are working on.

Mr. PICKLE. I can see that we might want to target it a little differently. But we have just now established policies based on your past proposals, and now you are anticipating making a recommendation to change them before we even put the regs in place. I do not know the status of the regs, and I suppose Dr. Wilensky can give us a more up to date picture of that. But I would view with considerable alarm any recommendation that would propose lowering rural payments. Our problem is we ought to be increasing them.

Mr. **Altman**. I agree with that. As a matter of fact, one of the reasons why we have not come forward with any new recommendations is just what you said. You have put in place many new legislative changes that we want to see the impact of. So I think it is fair to say that if we talk about a targeted approach, it is very unlikely that we would suggest taking it away. It is more focusing on special problems.

Mr. **Pickle**. All right. Well, Mr. Altman, one other question just briefly. I am not certain what HCFA has announced or intends to announce with respect to capital payment. I notice they are going to make some recommendations, but I do not know what they are specifically. I can understand your hesitancy in making specific recommendations about capital reimbursement, particularly about paying prospectively. I do understand, though, that you have done some research in this field. Can you tell me what your research has established, if anything, at this point?

Mr. **Altman**. Well, yes, as I indicated in my testimony, what the analysis suggests is that when hospitals were paid their total costs for capital, following the introduction of PPS, there was a major increase in capital spending at a much greater rate than the increase in operating expenses. Capital was going up much faster. That over the last several years, as the Congress has legislated increasing discounts for capital payments, plus a much tighter operating budget, we find that the growth in capital is much more commensurate with the growth in operating. So that currently the ratios are growing about the same rate.

Mr. **McGrath**. Would the gentleman yield? Jake, would you yield on that?

Mr. **Pickle**. I would yield to the gentleman.

Mr. **McGrath**. You are suggesting some sort of bookkeeping switch here from the operating side to the——

Mr. **Altman**. No, sir. No, I am just——

Mr. **McGrath**. Well, how do you explain that then?

Mr. **Altman**. Well, I think the sets of incentives are now more similar. But there is an argument to be made that it is still true that capital, there is more of an incentive to spend extra money on capital than extra money on operating.

Mr. **McGrath**. Obviously when it is cost based.

Mr. **Altman**. One is 85 percent cost based, and the other technically is not directly related to actual costs. So if you add another worker to a DRG, to a specific patient, you receive absolutely no more money to that.

Mr. **McGrath**. I understand that.

Mr. **Altman**. But if you add another piece of equipment you get more payment. So the argument in support of folding capital in is they are not equal yet.

Mr. McGRATH. Yes. I understand all of that. But your research which you have given to Congressman Pickle seems to suggest that all other things being equal that there was a way for the hospitals to transfer from one side of the ledger to the other side of the ledger, operating to capital, in order to meet this phenomenon of higher capital costs as opposed to stagnant operating costs.

Mr. ALTMAN. I would not say it quite that way. I do not think there was a transfer so much as a slowing down of capital expenditures, more in line with the growth in operating. A hospital has to be much more concerned today about adding new capital which invariably will add new operating expenses if it does not expect to receive comparable payments in return. And so I think it is a mistake only to look at capital payments and expect that those are why those decisions are being made. They are being made in a total context. And it may just be a statistical fluke that they are now working at about the same rate. I will not claim that you can draw a 1 to 1 correlation between the changes in the rules and the fact that they are now going up the same. They are going up the same which suggests that capital expenditures have been slowed down in terms of interest and depreciation. That is as far as the data tells you.

Mr. PICKLE. I thank the gentleman for his questions, and Dr. Altman, I would like to be kept advised about any recommendations that you might make. We have got a real problem with capital, particularly for a lot of these hospitals that have made intensive investments already, heavy investment in capital, while others have not. Some have invested just a little bit. And if you just establish a broad policy, you could affect a lot of the hospitals adversely. I know you will keep that in mind, and I hope we have a chance to visit with you about that.

Mr. ALTMAN. Well, Gail is going to be coming after me, and I would just say this, Mr. Pickle. Our preliminary analysis says that HCFA has done a very fine job in addressing expenditures of previous capital investments, a very sophisticated job of dealing with that issue.

Mr. PICKLE. Thank you.

Chairman STARK. And I might add to the gentleman from Texas and the gentleman from New York that it is our intention to schedule hearings on the proposed capital regulations the end of May, so we will have some time to look into that in much more detail. Stuart, I want to thank you and your Commission for the work you have done. I wanted just to summarize what I think we are going to hear today. I am quite sure the Administrator who will follow you will suggest that hospital costs are running higher than the rate of inflation, and we cannot continue that. And the hospitals will testify, I am sure, that they are not getting enough money. That pretty much stakes out the territory.

I would like to suggest that with credit going to the administration and your Commission and to the diligent work of the staff and members of this subcommittee, that in the last 3 years for which we have data, Medicare has done the best job of any payer in the United States in holding down hospital costs. I say that we are probably the largest insurance system, and with all due respect to CIGNA and Blue Cross and everybody else, we have done it. And to the clarion call that that is because we have cost shifted, I am only going to suggest this and ask you if your data would support it. If the hospitals in this country received for each case for which they provided service the Medicare rate, they would survive. On average, if the Medicare rate were the fixed rate, and Medicare was the single payer, the hospitals could live with that. Is that a fair statement?

Mr. ALTMAN. If you will permit me, Mr. Chairman, let me just modify your statement just a bit.

Chairman STARK. OK.

Mr. ALTMAN. I think, I agree with you that Medicare has done the best of any payer in controlling its expenditures in a way which is not arbitrary and hopefully not capricious, but which is tight and which distributes it in a reasonable way. But we have not developed a technique which translates our control and expenditures to controlling hospital costs. So we need to make that distinction.

Chairman STARK. And that was the intention actually of the prospective payment.

Mr. ALTMAN. Well, no, I think there was a hope that not only would Medicare control its expenditures, but this would translate into hospitals lowering the rate of increase in their costs, and I might add that there has been some of that. But the rate of lowering is less than we would have hoped for. And that is why we get into this argument, you and I and others who defend the Medicare rate, that we are cost shifting. Well, the truth of the matter is we are not cost shifting at all. We are paying, or Medicare is paying, what we consider to be a reasonable rate. Hospital costs continue to go up further, and then they look for other people to pay the bill.

And I would agree with you if there were more similarity between not necessarily identical, but more similarity in the incentives and the structure, if not the rates, between payers, we would be sending a much clearer set of signals that say you got to keep your costs within line with your payments or you are really going to go out of business rather than just find ways of moving the money around to the deepest pocket.

Chairman STARK. I would say one other thing. Although we politicians are heroic and strong people, one of our problems is that we have failed to allow hospitals to go broke and hospitals, I think, recognize that. The prospective payment system anticipated that some hospitals, those that were least efficient, would go out of business or merge. And because of politics, we really have not let that happen. And that is that weakness in the system of controlling costs. Now I am not suggesting——

Mr. ALTMAN. Well, I think it is stronger——

Chairman STARK. I mean I think it is wonderful to let hospitals close in everybody else's district but mine. But I think you would hear that same sentiment echoed 434 times.

Mr. ALTMAN. I think you deserve more credit than you are giving yourself. I think the deep pocket has shifted from the Government to the private payer, and now it is the private payers who are keeping those hospitals open.

Chairman **Stark**. Well, again, I want to thank you, and your testimony has been enlightening.

We will now look forward to having Dr. Gail Wilensky, who has been patiently waiting in the wings. She is the Administrator of the Health Care Financing Administration, and Gail, we have your testimony. I am going to let you expand on it or enlighten us in any way you can because I have a hunch that no matter what you say everybody is going to ask you about capital anyway.

Ms. **Wilensky**. Right.

Chairman **Stark**. Welcome back to the committee. Please proceed in any manner that you are comfortable with.

STATEMENT OF GAIL R. WILENSKY, PH.D., ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Ms. **Wilensky**. Thank you, Mr. Chairman, and members of the committee. I am pleased to be here today to discuss the performance of hospitals under the prospective payment system. We have now had 7 years of experience in prospective payment. Contrary to some predictions, the system has worked largely as intended. Cost increases have been curbed and that is the good news. Annual cost increases continue at double the rate of inflation, however. Hospitals, Medicare, and ultimately the country cannot afford such increases over the long run. That presents a challenge to us all.

The question that we need to answer is: What is the right price to pay hospitals? What does it take for an efficiently run hospital to treat a Medicare patient? We may not know exactly what the efficient payment level is, but the direction is clear. Occupancy rates now are low. The staffing per bed continues to increase as does the rapid diffusion of technology—technology that is often tremendously underutilized. The industry could be much more efficient than it is now.

Overall, hospital margins are positive and better than they were in the decades preceding PPS. In 1990, the American Hospital Association reported average hospital margins of 5 percent. Medicare operating margins for PPS-5, the latest available data, average 2.19 for all hospitals.

But margins should not be the primary focus. The proper payment level for efficient care is the issue we ought to worry about. In 1987 and 1988, PPS payments per admission for PPS hospitals increased 11.6 percent while market basket inflation was 10.4 percent. During the same period, hospital costs per Medicare case increased about 20 percent. If margins are becoming a problem, it is because hospitals do not have control of the costs. What is causing hospital costs to increase so much? The complexity of cases has increased, accounting for about half of the increase in Medicare payments per admission. Many claim that technology is a major contributor to cost increases. Beyond that, there are no easy answers.

We need to use economic incentives to organize efficiently. That way all payers will benefit. The administration does not pretend to have a quick or an easy solution to the problem of rising costs. We are proposing several changes to hospital payments that would help establish better incentives. Foremost among our plans is our proposed regulation to fold Medicare capital payment into the prospective payment system. The current cost-based system pays for whatever hospitals spend. It contributes to a race for technology.

Hospitals, particularly those with declining market shares, are competing with each other by stockpiling capital equipment and making other imprudent capital decisions. For each piece of equipment purchased, operating costs seem to go up to provide necessary staff, space and other services. Our proposed regulation provides an equitable approach to prospective capital payments. It provides for a 10-year transition and protections for vulnerable hospitals. Prospective payment for capital will end excessive Medicare subsidies of underutilized projects. That is one of our most important efforts this year.

Another effort where we can be more cost effective in hospital spending is in Medicare payments for medical education. Data has consistently shown that teaching hospitals are faring better on Medicare business than any other class of hospitals. This analysis has been supported by the analysis of ProPAC and also by the General Accounting Office. We should eliminate this extra payment. We propose to gradually reduce the indirect medical education adjustment from 7.7 percent to 4.4 percent in fiscal year 1992. We also want to pay a uniform amount for each resident based on a national average of their salaries.

We want to provide incentives to encourage efficiency in hospital outpatient departments where a growing amount of care is being provided. Our proposal to establish prospective rates would phase out the current inflationary cost-based payment.

We are also assisting rural communities to reconfigure their health care delivery systems. Specifically, we are implementing a program to develop rural networks of essential access community hospitals and rural primary care hospitals. The applications were sent out at the end of January, and we anticipate making awards no later than September. In addition, we have awarded almost 400 rural health transition grants for a total of $25 million. The grants will help small rural hospitals modify their health care services to adjust to market conditions and community health needs. We are currently preparing to review applications for 1991 grants to be awarded in September.

It is our hope that the transition grant program will support the trend of redirecting underused hospital resources to meet other community health needs.

Our proposals and other initiatives should be viewed as important downpayments on improved financial incentives for hospitals to provide quality care efficiently. The issue of inflationary health care spending goes beyond today's focus on hospitals to our Nation's health care system as a whole. Virtually, every area of health expenditures is being closely scrutinized to bring the growth of spending more in line with the remainder of the economy. This tough problem must be solved as we seek to expand access to care for all individuals.

We are actively promoting other cost containment strategies as well. Our efforts to encourage expanded use of coordinated care and to pursue payment reforms will conserve health resources and provide better value for health care dollars. While these activities contribute to cost containment, we need to foster a broader debate on the issues and to strive to identify strategies to cut costs while maintaining the highest standards of quality. Thank you, and I would be happy to answer any questions you have.

[The prepared statement follows:]

STATEMENT OF GAIL R. WILENSKY, Ph.D.
ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION
February 27, 1991

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

I am pleased to be here today to discuss the performance of hospitals under the prospective payment system and how we can help moderate the growth in hospital spending.

EXPERIENCE UNDER THE PROSPECTIVE PAYMENT SYSTEM

We now have had seven years of experience paying hospitals for inpatient care of Medicare beneficiaries on a prospective basis. Contrary to some predictions, the system has worked largely as intended, and the quality of patient care has been maintained. Cost increases have been curbed. And that is good news. Hospitals have played a significant role in helping the prospective payment system work as envisioned.

However, annual cost increases continue to run at double the rate of inflation. Hospitals, Medicare, and ultimately the country cannot afford such increases over the long run. That presents a challenge to us all.

Under the prospective payment system, hospitals, on average, fared extremely well in the early years. Although the hospital industry is now faring less well financially on Medicare patients, hospitals continue to have positive margins.

Since PPS, overall hospital margins have, year after year, exceeded average margins for the 20 years prior to PPS. Data from the American Hospital Association show that the 1990 average total revenue margin was 5.0 percent (it averaged 5.2 percent for the 7 years of PPS). In the 5 years prior to PPS, the average hospital total revenue margin was 4.7 percent (and 2.9 percent in the 5 years before that). Average Medicare margins for hospitals in PPS-5, the latest available data, were 2.19 percent.

It is also worth looking at hospital closures, often deemed the ultimate barometer of hospital industry distress. For 1987 through 1989, the Department's Inspector General reported that 233 hospitals closed. This represents about 4 percent of the nation's hospitals and about 1 percent of all hospital beds. That's a small fraction in an industry with overcapacity.

While any closure is of concern to its community, the Department's Inspector General found that over half of the hospitals that closed in 1989 converted to alternative health care settings and continue to meet the community's needs. The IG also reported that most communities have emergency and inpatient medical care available within 20 miles.

COST INCREASES

While I believe that Medicare, on average, continues to pay more than enough to compensate hospitals for efficient care, hospitals view it from a different perspective. Hospitals argue that PPS updates have been insufficient to cover increased costs. On average, increases kept pace with costs in the early years of prospective payment.

However, cost increases are now surpassing Medicare payments. In 1987 and 1988, PPS payments per admission for PPS hospitals increased 11.6 percent, while market basket inflation was 10.4 percent. During the same period, hospital costs per Medicare case increased about 20 percent. Medicare payments are not keeping up with hospital costs.

The question we all need to ask is what caused hospital costs to increase so much? The complexity of cases has increased, accounting for almost half of the increase in Medicare payments per admission.

Beyond that, there is no simple answer. Many claim that technology is a major contributor to cost increases. In most industries, technology reduces costs. It's a way to make the purchaser more efficient, not more costly. But a claim that hospitals need payment increases above inflation to compensate for technology argues that technology acquisition systematically increases costs for hospitals.

We all need to strive to develop a better understanding of the reason for increasing costs. The Medicare Hospital Insurance Trust Fund and the Federal government simply cannot afford to continue to pay for costs increasing at double the rate of inflation.

It is not just Medicare and taxpayer dollars at stake. Private payors know only too well how much they are affected by cost increases. We need to use economic incentives to get hospitals to organize efficiently -- that way all payors benefit.

Hospital costs parallel other health care costs. We all -- the Federal and State governments, hospitals, physicians, and businesses -- need to take a good hard look at how to improve the financial incentives to make further strides in reducing health care cost escalation.

HOSPITAL PAYMENT PROPOSALS

While the Administration does not pretend to have a quick or easy solution to the problem of rising health or hospital costs, we are proposing several changes to hospital payments that would help establish better incentives. Let me outline them.

Prospective Payment for Capital
Foremost among our plans is our proposed regulation to implement the statutory requirement to fold Medicare capital payment into the prospective payment system. Even though I hope in the future to discuss this specific topic in detail, I would like to make the following points. We believe the current capital payment policy is at least partially responsible for the cost pressures hospitals feel on the inpatient side. The current cost-based system, with payment based on whatever hospitals spend, provides little incentive to make prudent capital investments.

Medicare's current capital payment policy contributes to a race for technology. Hospitals, particularly those with a declining market share, are competing with each other by stockpiling capital equipment and making other imprudent capital decisions. And for each piece of equipment purchased, operating costs seem to go up to provide necessary staff, space, and other services. For example, if a hospital purchases an MRI, it must hire additional medical technicians, nurses, and other personnel to provide the services needed. Doctors also bill for related services. At the same time, a nearby hospital will purchase an MRI to be able to compete for the same business. As a result, unnecessary equipment and staff serve a small number of clients at an increased cost to you and me.

Our proposed regulation provides an equitable approach to prospective capital payments. It provides a 10-year transition period with a phased-in payment blend to a federal rate. Specific protections are available for vulnerable hospitals. A "hold harmless" payment methodology is included for hospitals that have recently made a capital investment. Such hospitals have the option to change to the federal rate if it is advantageous to do so. By folding capital into PPS, Medicare

will, over time, end excessive subsidies of underutilized projects.
I am sure that this will not be the last time you will hear me talk about capital payments or this proposal. This is one of our most important efforts this year and needs your understanding and support.

Rural Initiatives
We are also working to assist rural communities in reconfiguring their health care delivery systems. In many rural communities, maintaining virtually empty hospitals is not cost effective. Specifically, we are in the process of implementing a program to develop rural health networks of Essential Access Community Hospitals and Rural Primary Care Hospitals. The application packets were sent out on January 31, 1991, and we anticipate making awards by September.

In addition, we have awarded a second round of Rural Health Transition Grants that will help small, rural hospitals modify their health care services to adjust to market conditions and community health needs. In 1990, 211 grants were awarded to hospitals for a total of $9.4 million dollars. A total of 394 grants and $25.1 million have been awarded to date. We are currently preparing to review applications for 1991 grants to be awarded in September.

It is our hope that the transition grant program will support the trend of redirecting underused hospital resources to meet other community health needs.

Outcomes Research
We are working with the Agency for Health Care Policy and Research, which is responsible for research on the outcomes of various health treatments and procedures. The results of this research will provide hospitals and physicians with information on the effectiveness of medical practices. This information can be used by the medical community to educate and improve practice behavior.

Outpatient Departments
We must control spending in hospital outpatient departments. Medicare payments for hospital outpatient services increased from $3.5 billion in 1984 to $8.4 billion in 1990, an average annual growth of about 16 percent. As outpatient services continue to grow and to make up a larger share of Medicare payments, we need to establish a consistent payment system with incentives for efficiency.

We propose to establish prospective rates for surgical, radiology and diagnostic procedures performed in hospital outpatient departments. Payment would be the same regardless of whether the procedure is performed in an outpatient department, an ambulatory surgical center, or other center. This would be an interim step to a more comprehensive prospective payment system for outpatient services that would involve bundling of related services into payment for procedures.

As part of this proposal, we would remedy a long-standing problem with beneficiary coinsurance for outpatient services. Currently, the beneficiary pays 20 percent of whatever the hospital charges for a procedure, while Medicare pays 80 percent of a payment that is at least partially based on costs. Since charges are typically more than costs, the beneficiary is actually paying 30 percent, on average, of the total amount paid to the hospital. We are proposing to limit the coinsurance payment to 20 percent of the new prospective rates, which will lessen the burden on beneficiaries.

Medical Education
Another area where we can be more cost-effective in hospital spending is in Medicare payments for medical education. Data repeatedly show that teaching hospitals are faring better than any other class of hospitals on Medicare business. We are not alone in recognizing that the current teaching payments are too high. Both ProPAC and the General Accounting Office have stated that current medical education payments are too high.
The Administration wants to eliminate this subsidy to teaching hospitals by limiting payments for indirect medical education costs and reforming graduate medical education payment policy.

We propose to gradually reduce the indirect medical education adjustment from 7.7 percent to 4.4 percent in FY 1992, continuing to 3.2 percent by FY 1996. We would also base the adjustment on the ratio of interns to patients rather than the current ratio of interns to beds.

We also want to change the way we pay for graduate medical education. Currently, we pay hospitals a per resident amount based on hospital-specific costs for direct medical education costs. By basing payments on historic costs, Medicare is paying the excessive costs built into the hospital system. As a result, GME costs are high, and they vary from hospital to hospital with payments ranging from $10,000 to $100,000 per resident. Our proposal would provide a uniform amount for each resident based on a national average resident salary.

Our proposals for capital and other changes in hospital payments, along with our rural initiatives, should be viewed as important down payments on improved financial incentives for hospitals to provide quality care efficiently.

In the long run, reforming capital payment will provide additional incentives for prudent investment decisions. Outcomes research will contribute to cost effectiveness by providing us with information on optimal treatments, thus eliminating wasteful or unnecessary services.

CONCLUSION

The issue of inflationary health care spending goes beyond today's focus on hospitals to our nation's health care system as a whole. Virtually every area of health expenditures is being closely scrutinized to bring the growth of spending more in line with the remainder of the economy. This tough problem must be solved as we seek to expand access to care for all Americans.

We are actively promoting cost containment strategies which will help. Our efforts to encourage expanded use of coordinated care will conserve health resources and provide better value for our health dollars. We are also pursuing payment reforms that provide incentives for the effective and efficient use of physicians' services, nursing home care, and home health care. We are also studying the value of combining, or "bundling" payments for certain procedures such as cataract and heart bypass surgery.

While these activities contribute to cost containment, we need to foster a broader debate on the issues and strive to identify strategies to cut costs while maintaining the highest standards of quality.

Thank you. I will be happy to answer any questions you may have.

Chairman **Stark.** Mr. Moody.

Mr. **Moody.** I will defer to my colleagues.

Chairman **Stark.** Mr. Levin.

Mr. **Levin.** Let me just ask one question. Hi, welcome. You heard our discussion on IME, and you have had a chance to talk about it with others, and with me individually. Any further comments that you think are relevant at this time?

Ms. **Wilensky.** Let me try to just comment briefly. I very much agree with the sense of the discussion that I heard Stuart providing, and also with the concern that you raise. We really have a problem that we are addressing. The payments we are making for IME, exceed the amount that is associated for teaching with regard to the Medicare patients, I think you would agree with that.

Mr. **Levin.** I do.

Ms. **Wilensky.** I think most of the analyses show that. I personally think, although it can be a fight among us analysts, that the amount ProPAC is now recommending by ignoring disproportionate shares as opposed to the 2 percent if you include disproportionate share, is a funny way to go about it, but it is a really an analytical issue. There is some debate as to whether the real costs that are associated with teaching are 10 or 4 percent, and it has to do with whether or not you include the disproportionate share in the analysis.

The more fundamental question is a hard one, and it really gets to the issue of supporting teaching hospitals in very nontargeted ways, number one, and, two, potentially these hospitals are not very good sites of care for primary care. And I think both of those are really problems especially the targeting one, that was raised in the earlier discussion. In general, it may be true that teaching hospitals provide uncompensated care or charity care. But what is very clear is that in the specific, the relationship is pretty bad. For example, Henry Ford Hospital, in the middle of inner-city Detroit, three-quarters of the way downtown where there are lots of difficult social problems, takes on functions that St. Joseph's in Ann Arbor or University Hospital in Ann Arbor, or lots of other teaching hospitals take on in a very different manner.

So the first point is that paying more to teaching hospitals is, to put it mildly, a rather bad way to target to uncompensated care. The second issue that is raised is that teaching hospitals probably are not very good places, on average, to provide primary care to uninsured people or poor people or probably to most people. That has traditionally not been their major function. Their functions are as teaching institutions and in providing secondary and tertiary care. So we have the additional problem that even for those that are providing major sources of care for uninsured people, there is a pretty good chance it is at one of the places we would less like to have it provided than more. And so for both of those reasons, we really, I think, have a problem with using IME as a subsidy for other social problems.

I appreciate your frustration that until we get around to deciding how we are going to pay for social problems, we run some risk, even if we now do it inefficiently, of removing those dollars. I guess the argument on the other side—and this is a political call, and you have been in this business a lot longer than I have—is that until we can start showing some more convincing reason to believe that we understand how to control health care cost increases, that there is not going to be a lot of inclination to take on the problems of the uninsured. I do not think we have to solve the cost problem first. I do not want you to think that is what I am saying. I just think we are going to need to work on these problems together, and that makes the task, I think, particularly difficult. The current situation is a pretty inefficient way to go about it, and, at best, deals with it only in the aggregate.

Mr. LEVIN. OK. One of the problems is that as we have worked to get hospital costs under control, the number of uninsured has also risen. Not that we have gotten hospital costs fully under control, but somehow that has not unleashed our ability to attack the problem of the uninsured, and there are so many human costs and inefficiencies in our present system, they are really mind-boggling when you talk to people directly rather than just looking at them as statistics.

Ms. WILENSKY. I would hate to think that you think we have hospital costs under control when Medicare part A next year is going to increase at 10 percent.

Mr. LEVIN. I did not say under control.

Ms. WILENSKY. OK. Just better.

Mr. LEVIN. But better, more under control, or less under lack of control.

Ms. WILENSKY. OK. [Laughter.]

Mr. LEVIN. Thank you.

Chairman STARK. Mr. Moody.

Mr. MOODY. You heard the discussion that you Stuart Altman had with some of us, I am sure. I assume you were here.

Ms. WILENSKY. Yes.

Mr. MOODY. Do you have any comments on my question I posed to him about the need for better data regarding fixed versus variable costs? Is there any kind of care, for example Medicaid, which we should expect to cover only variable costs, or should we expect it, too, to cover fixed costs, some portion of fixed costs? How do we know if we do not even know even those numbers?

Ms. WILENSKY. Let me back up. You asked a question about whether much of the data exist. The information that we know about variable costs and fixed costs is primarily information that is available from econometric analysis and not from accounting data, because of the difficulty of getting and allocating the data in this multiproduct industry. I think there are a couple different ways to go about the issue. There is a real question about whether we want to have the Government, the payer for the poorest people, covering marginal costs or average costs for the poorest payer.

In the long run, if you do not cover average costs, the industry cannot survive. I will say that I think in this particular industry, there is an awful lot of over capacity in the aggregate. And that at some point we do need to acknowledge the fact that unless we have less beds and somewhat less facilities, we are going to be paying very high fixed costs because fixed costs are a large part of supporting overcapacity, and we are not going to achieve the kind of savings that we need.

So we need to keep that in the back of our mind. There are two directions we could go. We could try to require additional information, give accounting rules, give directions. We do that. We do that under IRS rules all the time to try to understand variable costs and fixed costs and then make some decision about what we think Medicaid should pay. After all, in prescription drugs, the Congress has just directed that we pay the lowest cost. We are not saying we should pay average costs for prescription drugs. We are saying that we ought to use the lowest cost on the market for Medicaid because this is a program for our poorest people.

So it is not clear to me that there is any agreement that we ought to pay average hospital costs, nor would I say that average hospital costs ought to be assumed as being efficient. The other direction we might want to go is to try to understand what an efficiently organized hospital would require in order to provide care of different sorts, at least of gross categories. We do not really know very much about that. What I can say with great comfort is the industry is not efficiently organized. I can say that because of the low occupancy. I can say that because of the rate at which technology is diffused. I can say it because of the staffing increases that have gone on at the same time we have had reductions in patient days.

But I can say all of that much easier than I can tell you what the efficiently organized hospital would require. I can just say this is not it, and we are not even in the relevant market. It does not pass "the man from Mars" test when you look at it.

Mr. MOODY. Right. I guess I was asking the question of how can we make a decision on whether to charge Medicaid with some of the fixed costs if we do not even know what these costs are? We cannot even separate them out.

Ms. WILENSKY. Well, there are at least two or three basic questions you need to ask yourself to decide whether that is really the issue. One of them is just a philosophical issue concerning prescription drugs. You the Congress have just decided you are going to pay the lowest cost. You are not going to pay average cost.

Mr. MOODY. Pay marginal costs.

Ms. WILENSKY. You are going to pay the lowest. I do not know whether that is the marginal cost or not. There is no reason to assume it is the——

Mr. MOODY. No.

Ms. WILENSKY. It is certainly not the longrun costs.

Mr. MOODY. It is not the full average total cost including fixed.

Ms. WILENSKY. Right. So part of it is just that you need to decide if you knew the fixed and variable costs, would you want to pay on that basis anyway? Second, you really do not want to look at the fixed costs and the variable costs that exist now unless you think that what we have got now is where you want to be.

Mr. MOODY. No, but if you break the two components out, you can project them, and you know where you are going to be, it does not mean that you are static stuck with that number. It just means that they grow at different rates typically. And different policy instruments are necessary to contain each of those two.

Ms. WILENSKY. There is a lot of information, policy options and suggestions we could provide if we had more information.

Mr. Moody. Right.

Ms. Wilensky. Including just how serious this problem of empty beds and low occupancy hospitals is. We think it is very serious because we think fixed costs are a large part of total costs.

Mr. Moody. Well, they are the majority of the total costs in many case, are they not, in hospitals?

Ms. Wilensky. Well, we think so, but we obviously would be in a better position to know if we had more specific data. What you will hear if you push us to go this direction is the screams that we have already been hearing about our cost reporting going up probably five decibels. Now it is important information to make certain decisions. It is not information that will come easily. For example I would cite the quality of the responses we got with regard to the occupational mix question.

Mr. Moody. Right. Even though as Stuart Altman said, they must internally need this information when they work out their preferred provider and all sorts of other deals, side deals they make with different payment groups. They have in their bottom drawers, as he said, data on their irreducible minimum variable costs because it would make no rational sense to sign a contract that would go below that. So they must know what it is.

Ms. Wilensky. Well, the question, though, is if you want to know some of that information because you want to know the policy direction you would like to go, do you need to know that for each and every hospital or could you just do a sample of hospitals, look at the data, and be able to understand fixed and variable costs for different types of hospitals. You could, at least, direct any research into a different path without having data for all 7,500 hospitals.

Mr. Moody. Right. Well, if we knew what it was in econometric sense for the aggregates, then hospitals that deviated, who were outliers, if you will——

Ms. Wilensky. Right.

Mr. Moody [continuing]. Would begin to realize that they themselves need to make some serious cost containing moves.

Ms. Wilensky. And what I regard as——

Mr. Moody. So that would fit in with the PPS approach?

Ms. Wilensky. Right. Definitely. That was the point I was going to make. It would definitely fit in with the PPS approach which uses economic incentives to force behavioral changes.

Mr. Moody. Yes.

Ms. Wilensky. And not just to change reimbursement.

Mr. Moody. OK. Thanks a lot.

Chairman **Stark.** Mrs. Johnson.

Mrs. Johnson. Thank you, Mr. Chairman. I want to pursue the same kinds of questions that my colleague from Wisconsin was pursuing. I also am very concerned about your recommendations in regard to medical education, not because I think your analysis is wrong, but because the practical effect deeply concerns me, and I do not see any other way to address it. So I personally am reluctant on that score. But I have a lot of questions about your outpatient recommendations. It seems to me that perhaps you are just recommending a reduction in reimbursements in order to stimulate efficiencies. But do you have any data that analyzes the increase in outpatient costs since 1984 and looks at them from the point of view of the impact on outpatient services of the DRG system which very clearly kept some people out of the hospital and left outpatient services in hospitals dealing often with more serious patients.

In my experience, the ways that have developed to deal with those patients have been much less costly than admission, and often have been better care, but how much of this increase in costs is due to the different role that outpatient services are often playing in hospitals combined with the increase in the number of elderly and the increase in longevity?

Ms. Wilensky. Let me just briefly touch on IME and then mostly talk about the outpatient issue. In the Department, we have a small task force with HCFA and the Public Health Service and others looking at the issues of how medical education, and especially graduate medical education, is financed and the Government's role in that. We will be presenting the Secretary with some potential options for his consideration following a conference in April or early May to look at these issues with the broader community. And the reason I raise this is because I think you will continue to see pressure exerted as long as it is clear that the payments that the Medicare trust fund is being asked to make to IME ~~are~~ way beyond those that involve teaching and also that IME is a very clumsy way to cover uncompensated care. We are using the trust fund, which is supposed to be set aside for a particular purpose, for purposes that it really was not intended.

And we will continue to be exerting this pressure as prudent watchers of the trust fund should, I think. Now I say that only because we also feel that there is another issue being raised, which is how should the Government interact with graduate medical education, and if not from Medicare are there other ways? And I do not want to promise you that we will come up with better ways or other suggestions. I want to at least assure you that we are concerned about this. We are looking at it. We will have a conference and see whether that leads to some suggestions. But it is clear that we are using trust funds for unrelated purposes, and it looks like they are being used in a pretty inefficient way. But we understand that to just pull funds out and to not be willing to say that there is a legitimate question being raised, is not very responsive.

In regard to how we want to pay for outpatient costs, we are not just trying to reduce the payment. We tried that last year, and we did not get very far. This has a different direction, although it is not as far as we may be able to go. In the fall, we are going to be submitting a report about prospective payment for ambulatory care. What we are now doing is to have a preliminary version of that being proposed in the President's budget where we would look at the lower of the payments of outpatient versus ambulatory surgery centers, and use the lower of those rates to establish for ambulatory surgery, radiology, and diagnostic tests the proper payment. We want to take whatever is the most efficient and use that as the proper payment level.

It is possible we will be able to come up with a better perspective payment in our report in the fall. Our concern has been that this area is increasing in expenditures very rapidly, 13 to 15 percent per year. It has gone up very rapidly, and this is a reasonable approach, in the interim, in three areas. For fiscal year 1992, we are only proposing to go after high volume surgery, to use the lower of the ASC or the outpatient department rate for the payment rate. We think it is prudent. We may be able to do a little better, but when you see expenditure increases of the kind that we have been seeing, it is hard to just sit back and wait.

Personally I would much rather have a per capita amount and let the health care group decide whether the best place is in the hospital, in the ambulatory surgery center, or in the office.

Mrs. JOHNSON. This brings me to the second aspect of my concern on this outpatient stuff, which I have seen operate in my own community, and I have grave concerns about it. Often you can provide the service at some ambulatory center for very much less than the community hospital can provide the service. But the less costly clinic does not have to take care of the complex cases. They cream. They do not have to have the backup resources, and I am really afraid that in looking at all outpatient care and reimbursements for outpatient care in one across-the-board manner without regard to the other responsibilities that a community hospital has that do affect their costs of doing outpatient surgery, for example, that you will force on them a reimbursement rate that will not enable them to stay in the business of ambulatory care or outpatient surgery.

If they lose that, which is often one of their major sources of revenue which cross-subsidizes some of their losses, the consequences may be dire. I appreciate your wanting to get costs more aligned with the individual services, but community hospitals do serve a lot of needs that private ambulatory centers do not. Perhaps the best analogy is what has happened in the physician sector where we have a lot of physicians now who simply do not serve the public sector. And I worry about looking at outpatient payments regardless of facility and treating them all the same when they play different roles in the health care system.

Ms. WILENSKY. The problem is that when we pay the other way, we pay those outpatient departments that are taking on other functions and those that are not. And it really gets into the problem of trying to use one set of monies for three or four different purposes. You tend to do all of them not very well, and really it is an issue that Stuart Altman was raising earlier. If you take funds that are supposedly used for one function and try to have them do a little of that and a lot of three other things, you have very little control over what happens, and you frequently do not do any of those functions very well.

And the issue of trying to make sure that we are in the right configuration and have the right groups of people doing things is a much broader question than the specific payment for a particular service and outpatient department.

Mrs. JOHNSON. May I just pursue that one more question?

Chairman STARK. Sure.

Mrs. JOHNSON. Let me just give you an example of my concern. Sometimes in the big negotiations that go on over fees, we are beginning to see happen sometimes now big payers say, "well, I will build for you some outpatient surgical suites because you, this group, can do it cheaper than the hospital can do it." So they build that new capital investment which duplicates the capital investment that is already out there. Patients pay less for the service, but in the end when a patient is more complicated or cannot be handled by that lower cost of form of care, he or she is popped into the system that has to care for them. Now the costs in that system are very much higher because they can no longer have certain routine kinds of patients because of the drain out from these other bodies.

I worry about duplicating those capital facilities as if we were saving costs when I am not at all sure in the global systemic sense that we will save costs. That is just the concern I have and the perspective from which I will watch this issue develop.

Ms. WILENSKY. Fine.

Mrs. JOHNSON. Thanks.

Chairman STARK. Thank you. In response to your testimony, my sense is that the committee is not looking to get the additional budget savings all by itself.

We are going to hear from the hospitals in a few minutes. I am concerned about the direct medical education where I think you and I agree, Gail, that where the costs of an intern or a resident run from $10,000 on the one end to $120,000 on the other end, my suspicion is, and you probably know from the IG, that somebody is cooking the books someplace. I mean there just cannot be that much difference in dormitory or if there is——

Ms. WILENSKY. We worry about how costs are accounted.

Chairman STARK. Yes. Cost allocation is, I am led to believe, approaching breaking some laws. But in any event, is it fair to reassure some of the hospitals that where there were no overt felonies being committed, the administration is apt to be as sympathetically inclined as this committee to find a gentle way for some of these institutions to repay what they may owe the Federal Government as an alternative to immediately closing them down? Is that—do you suppose that is in the——

Ms. WILENSKY. It is certainly not our intent or interest to close them down.

Chairman STARK. And that is what I have said.

Ms. WILENSKY. I mean there are obviously some distinctions between——

Chairman STARK. And I understand that all the numbers are not in yet.

Ms. WILENSKY. Right.

Chairman STARK. But I just wanted to sort of get that on the record that, as I say, that absent any wanton——

Ms. WILENSKY. Criminal intent.

Chairman STARK [continuing]. Disregard of the law, I think that we might try and find a way to help them although I think the money should be paid back. I really have that sense.

Ms. WILENSKY. And we have been very concerned about the variations in costs that are reported to us.

Chairman STARK. Yes. And I think I would support you in looking at some sort of a national rate. I mean I think this is a good time to bring it up. We pay one rate to new docs and new nurses who are going over to the Persian Gulf to fight; right? And they may come from Ohio or they may come from Connecticut or California where they may earn different amounts of money, and it would seem to me we might be able to find one rate to pay residents and interns.

Ms. **Wilensky**. And we are going to pay one rate under physician payment reform for the particular service.

Chairman **Stark**. In time, yes, we are, with God and the AMA willing. I am not sure who is more important in that. Now I would like to mention an issue, and it seems to me has been brought up by Stuart and by many members of this committee. We are in the data age. And you have done a good job for us in outlining the possibility of how we could have uniform cost reporting for hospitals, and I gather the ball is now in our court. You have already proposed or suggested to us some of the problems and some of the ways this could be done. I do think it is important, and it may be something to work on this year when we are not going to have a lot of time or money to work on new programs, and I would rather suspect we are not going to do an awful lot of budget cutting, unless you suddenly recommended that we should also spend that same $2.8 billion within this subcommittee, and I do not think that is really what, in all fairness, you had in mind.

There has been some concern about the data information systems in part A and part B in general. Government computers are not all the same, and collecting claims data in some areas takes longer. We have 11 intermediaries, or 12, 15, or something like that. Why we do not use one computer program for all of them is something that I just cannot understand. It would seem to me it would make our job simpler. They might all complain, the ones whose computer program we did not pick.

I think with all the resources we have, and our ability to require some uniformity for all the bills we pay, that we ought to be able to get a lot more efficient——

Ms. **Wilensky**. I agree.

Chairman **Stark** [continuing]. In the way we collect data and how we disseminate it, and the clarity with which it is displayed. It would sure make our job a lot easier, and it would help with this issue that we are hearing all about—charity care. I understand that it is next to impossible to find a unanimous definition, but at some point we are going to have to make one, and then at least we can compare hospital to hospital more easily and it will make it easier.

The other thing I want to ask you about because it is going to come up, and it is not the subject of the hearing, but we will probably get to discuss it in May. I am, as you know, quite sympathetic to the approach you are taking on hospital capital payments, and you were kind enough to give me some initial data on the hospitals. I am now going to ask for some kind of a formula that I can understand in a broad sense so I can look at hospital A in my district and say this is how I would apply what I understand are the rules. And I want to be able to do it with my shoes and socks on. That is the limit of its complexity for me. And so if I could add that request to all the other wonderful things you have done for us, why——

Mr. **Gradison**. Would you yield, Mr. Chairman?

Chairman **Stark**. I would be glad to yield.

Mr. **Gradison**. As you may recall in the meeting we had down the hall here, I requested and was told we would get a worksheet so that we could take those numbers.

Ms. **Wilensky**. Yes.

Mr. **Gradison**. And I think it is the same thing. I think it would be extremely helpful.

Ms. **Wilensky**. Yes.

Mr. **Gradison**. So we can sit down and drop the numbers in, or at least even make that available to our hospitals so they can do it themselves if they want to and see how they fair.

Ms. **Wilensky**. I think around next week is when we plan to have it.

Mr. **Gradison**. Super.

Chairman **Stark**. OK.

Ms. **Wilensky**. Let me address——

Chairman **Stark**. Please.

Ms. **Wilensky**. Mr. Stark, the issue we were raising with regard to the need for information and more uniformity is one we are extremely interested in. I have been concerned that not only do we not have the right information, but also we frequently ask for too much information that nobody, including us, uses. I mentioned to the hospitals, since we have been doing a lot of discussing with the hospital industry in the past few months, that one of the areas I would like us to consider is the cost reporting forms and whether or not there are elements that we ask for now that we do not need, as well as whether there are ways to get other information that we might use.

And I think that is an issue we really need to look at. I have mentioned this also to OMB and they are sympathetic, and it is one issue that we plan to pursue. In addition, we are very concerned about the lack of uniformity among our payers, the fiscal intermediaries and the carriers, and we have been working since last spring on trying to rethink how we pay bills under Medicare part A and part B. We have some 84 or 85 fiscal intermediaries and carriers which is a very large number, and we also have an enormous amount of variation in terms of who does what and how they do it.

And we are trying to rethink how we might make use of the information and electronic advances that have occurred over the last 25 years. We are basically using 1965 configurations, not the technology, but the configuration, and we think there are probably much better ways to process claims. So we will be coming forward in we hope the not-too-distant future with administrative ideas and probably legislative ideas to do things in a more efficient way. I think that we can, and we would be glad, obviously, to work with you and with the committee as we go about that.

Chairman **Stark**. That is wonderful because I have got to believe that every hospital that is out trying to float a bond issue is certainly handing out a whole lot of information to those underwriters that may be completely different from the information we are seeing. And if somebody is going to invest a couple million dollars in an institution, maybe the information they are asking for is more important than what we are asking for. I have seen some of the reports, and they boggle the mind just how to find your way through them. So lots of data is there, and I think you are right on target to say, look, do we need it, can we simplify it, can we get it more quickly and store it electronically, and can it be produced often as just a byproduct of some other system, which would be wonderful. Thank you very much.

Ms. **Wilensky**. Good.

Chairman **Stark**. Appreciate it.

Ms. **Wilensky**. And if the worksheets and the information about how different types of hospitals would fare will not be available by, say, the end of next week, we will be sure we get back. But I think that is about the timeframe.

Chairman **Stark**. Thank you. Thank you very much.

Our next witnesses, and it is the intention of the chair for those of you whose tummies are rumbling to work straight through lunch, and so those of you who might like to eat before or after any particular panel should go right ahead. Our next witnesses are a panel consisting of Jerry Anderson, the director of the Center for Hospital Finance and Management at Johns Hopkins, and Hugh Long, associate professor, Tulane University. Gentlemen, if you would like to summarize your testimony or expand on it in 5 or 7 minutes, we would appreciate it. Without objection, your prepared testimony will appear in the record in its entirety, and at completion we will ask the members to inquire about those areas in which they are most interested. Dr. Anderson, would you like to start?

STATEMENT OF GERARD F. ANDERSON, PH.D., DIRECTOR, CENTER FOR HOSPITAL FINANCE AND MANAGEMENT, JOHNS HOPKINS UNIVERSITY

Mr. **Anderson**. Mr. Chairman, members of the committee, I appreciate the opportunity to testify this morning. The 1980s were the decade when both the public and private sectors developed initiatives designed to control health care costs. Evaluations of individual initiatives suggest that many of these efforts were successful in controlling health care costs. Therefore, it is surprising that after controlling for inflation and other factors, health care costs rose faster in the 1980s than in any previous decade. In contrast, other industrialized countries were able to control health care costs increases during the 1980s.

The data also suggests that all the major payers experienced approximately the same rate of expenditure growth during the 1980s suggesting that no one has found the solution. One of the major cost containment initiatives of the 1980s was PPS, and one of the primary objectives of PPS was to encourage hospitals to become more productive. In 1988, I testified before this committee that hospitals had made few productivity gains between 1983 and 1987. I have additional data to present today, but unfortunately my overall conclusion remains the same.

Between 1982, the year before prospective payment, and 1989, the year where I have the most recent data, the number of full-time equivalent personnel per occupied bed increased by almost 25 percent with hospitals adding one full-time equivalent employee per occupied bed. Increases with skill levels of employees made effective increase even greater. At the same time, hospitals have become more capital intensive, spending a greater share of their total budget on capital. Hospitals used almost twice as much capital resources per day of care in 1989 than they did in 1982.

More sophisticated analyses take into account changes in hospital output before making productivity calculations. However, all the data which I have seen and research which I have done, suggests that hospital productivity has shown little change in response to PPS, and this is starting from a base in 1982 where hospitals did not have a financial incentive to be efficient. This year ProPAC is recommending a 1 percent adjustment for productivity to be shared equally by the hospitals and the Medicare program. Perhaps we need a more ambitious goal than that.

Another indicator that overall efficiency in the hospital industry has declined is hospital occupancy rates. Between 1982 and 1989, overall occupancy rates declined from 75 to 66 percent. A more compelling statistic, however, is that in 1989 over half of the hospitals were less than half full on any given day. By way of comparison, the usual standard for efficient hospital operation is between 80 and 85 percent. What is surprising is the lack of a hospital response to declining occupancy rates. They reduced the number of beds set up and staffed by only 8 percent between 1982 and 1989, at the same time the number of inpatient days declined by 19 percent.

What is most surprising is that both of these factors did not seem to affect the hospital's bottom line. Between 1982 and 1989, the hospital's total profit margin, as a percentage of total revenues, was approximately 5 percent. And this was true for both 1982 and 1989. In fact, from a financial perspective, the decade of the 1980s was a much better decade for the hospital industry overall than the 1970s when profit margins averaged 2.5 percent.

A second cost containment initiative developed in the 1980s gave States much greater flexibility to set their payment rates. Legislation passed in 1980 requires Medicaid programs to pay the cost which must be incurred by economically and efficiently operated hospitals. There is a great deal of litigation over what is the definition of cost and whether you use marginal costs or average costs and what is an efficiently and economically operated facility. Working with four States and using Medicaid data, I have developed a model which shows that the average hospital is between 10 and 20 percent inefficient compared to the efficient hospital in its own peer group. If the comparison is made to the hospital with the best demonstrated practice in its peer group, the degree of inefficiency is much greater. The results seem to show wide variations in hospitals and show that considerable savings can be obtained if all hospitals followed the best demonstrated practice of their peers.

In 1990s, Congress is going to have to resolve one very important hospital payment issue. The issue is going to be what standard is used to set hospital payment rates. Both Medicare and Medicaid use cost as the basis for setting rates or evaluating if payment rates are adequate. If costs continue to be the standard, it is unlikely that we will ever be able to control health care costs.

There are alternatives to using costs as a standard. Other countries establish budgets without even calculating hospital costs. In most of these countries, the government negotiates with the hospital over the budget, and the hospital operates within the budget.

Cost containment can occur without damaging quality. Maryland implemented an all-payer rate setting system in 1972. When the program was introduced, Maryland's hospital costs per capita were the fourth most expensive in the Nation. In 1989 after 17 years of cost containment, Maryland was the 27th most expensive. It is hard to measure quality, but a recent ranking by academic physicians listed the Johns Hopkins Hospital as the best hospital in the Nation and the second-best health care system after the Mayo Clinic. Several weeks ago I spoke to the Maryland Hospital Association, and they still endorse all-payer rate setting in Maryland as the best way to pay for uncompensated care in the absence of universal health insurance coverage. I would be pleased to answer any questions.

Chairman **Stark**. Thank you.

[The prepared statement follows:]

STATEMENT OF GERARD F. ANDERSON, PH.D., DIRECTOR
THE CENTER FOR HOSPITAL FINANCE AND MANAGEMENT
JOHNS HOPKINS UNIVERSITY

Mr. Chairman, members of the Committee, my name is Gerard Anderson. I am the Director of the Johns Hopkins Center for Hospital Finance and Management, Co-Director of the Program for Medical Technology and Practice Assessment, and Associate Professor of Health Policy and Management at Johns Hopkins University. I appreciate the opportunity to testify this morning.

The 1980s were the decade of cost containment initiatives. Both the public and private sectors developed multifarious initiatives designed to control health care costs. Evaluations of individual initiatives suggest that many of these efforts were successful in controlling health care costs. Therefore, it is surprising that after controlling for inflation and other factors, health care costs rose faster in the 1980s than in any previous decade. The data also suggest that all the major payors experienced approximately the same rate of expenditure growth during the 1980s -- approximately 11 percent per year.

One summary statistic commonly used to measure the overall effectiveness of cost containment initiatives is the percentage of the Gross National Product (GNP) spent on health care. It takes into account overall inflation, population growth, productivity improvements and other factors. In 1980, we spent 9.0 percent of the GNP on health care. By 1989 the percentage had grown to 11.5 percent -- an increase of 2.5 percentage points.

Of course, we could have spent more on health care in the absence of these cost containment initiatives, but overall health care spending rose faster in the 1980s than would have been predicted by long-term trends. Between 1960 and 1980, spending on health care as a percentage of GNP increased approximately 2 percentage points per decade. If this trend had continued in the 1980s, spending would not have reached 11.0 percent until 1990, and we would be spending $30 billion less in 1991 than we will actually spend.

In contrast, other industrialized countries were able to slow their rate of growth in health care spending during the 1980s. Canada, Germany, Japan, and the United Kingdom spent approximately the same percentage of their GNP on health care in 1989 as they spent in 1980.

One of the major cost containment initiatives of the 1980s was the Medicare Prospective Payment System (PPS). It has been almost eight years since the passage of the PPS, almost long enough to determine if PPS has met some of its original objectives. One of the primary objectives of PPS was to encourage hospitals to become more productive. PPS followed many years of cost based reimbursement, which gave hospitals what was essentially a "blank check" and certainly did not encourage efficiency. It was anticipated that by changing the financial incentives through PPS, hospitals would be encouraged to become more efficient.

In 1988, I testified before this Committee that hospitals had made few productivity gains between 1983 and 1987. I have additional data to present today, but unfortunately my overall conclusion remains the same. In spite of strong financial incentives for hospitals to become more efficient, productivity has remained relatively constant and may have actually declined in the period from 1982 to 1989.

In Table 1, I use several indicators to compare the efficiency of the hospital industry in 1982, the year before PPS, to hospital efficiency in 1989, the most recent year for which I have complete data. Between 1982 and 1989, the amount of capital and labor increased per unit of output -- signifying a decline in productivity. The number of full time equivalent personnel per occupied bed increased by almost 25 percent with hospitals adding one full-time equivalent employee per occupied bed. At the same time, hospitals become more capital intensive, spending a greater share of their total budget on capital. Hospitals used almost twice the amount of capital resources to produce a day of care in 1989 as they did in 1982.

More sophisticated analyses take into account changes in hospital output before making productivity calculations. For example, the overall Medicare case mix index (based on DRGs) increased approximately 25 percent between 1982 and 1989. Assuming all of this increase is case mix is real, hospital productivity has still decreased since hospital inputs (capital and labor) have increased by more than 25 percent. When ProPAC computed productivity changes and adjusted for case mix and additional factors, their 1990 Report showed that according to certain measures hospitals achieved very small productivity gains and according to other measures hospital productivity actually declined between 1982 and 1989. All of these data suggests that hospital productivity has not increased substantially in response to PPS, even when this is starting from a base where hospitals did not have a financial incentive to be efficient.

Another indicator that overall efficiency in the hospital industry has declined is hospital occupancy rates. Between 1982 and 1989, overall hospital occupancy rates declined from 75 to 66 percent. A more compelling statistic, however, is that in 1989, over half of the hospitals were less than half full on any given day. By way of comparison, the usual standard for efficient hospital operation is between 80 and 85 percent. What is surprising is the lack of a hospital response to declining occupancy rates, they reduced the number of hospital beds set up and staffed by only 9 percent between 1982 and 1989 at the same time that the number of inpatient days declined by 19 percent.

All of these factors did not seem to affect the hospital's bottom line. In both 1982 and 1989, the hospital profit margin as a percentage of total revenues was approximately 5.0 percent. In fact, from a financial perspective , the decade of the 1980s was a much better decade for the hospital industry overall than the 1970s -- when profit margins averaged 2.5 percent.

A second cost containment initiative developed in the 1980's gave states much greater flexibility to set their payment rates. Legislation passed in 1980 requires Medicaid programs to pay the costs that must be incurred by economically and efficiently operated hospitals. Working with four states and using their Medicaid data, I have developed a model which shows that the average hospital is between 10 and 20 percent inefficient compared to an efficient hospital in that hospital's own peer group. The model groups hospitals with similar clinical practices together, divides the hospital into approximately 30 departments, and selects as the standard the hospital whose cost per case for a specific department and specific DRG are at the median. Hospital departments whose cost are above the median within a DRG are defined to be inefficient. If the comparison is made to the hospital with the best demonstrated practice in its peer group, the degree of inefficiency is much greater. The results seem to suggest wide variations in how patients are treated in various hospitals and show that considerable savings can be obtained if all hospitals followed the best demonstrated practice of their peers.

The basic question is why has there been so little change in hospital behavior. One explanation could be that hospital profit margins were higher in the 1980s than they have ever been. Students of organizational behavior have suggested that organizations are reluctant to change their mode of operation unless they are compelled to do so. Research on individual hospital behavior by Judy Feder and Jack Hadley has suggested that the only hospitals which changed their behavior were hospitals facing financial problems. Most of the problems for these hospitals were caused by uncompensated care and not by inadequate payment by public insurers.

In the decade of the 1990's, Congress is going to have to resolve one very important hospital payment issue. The issue is what standard will be used to set hospital payment rates. It may be necessary to move away from costs as the standard.

In 1980, the Congress said that Medicaid must pay the costs which must be incurred by economically and efficiently operated hospitals. Hospitals in over 30 states have sued the Medicaid program over the adequacy of their payment rates and most of the litigation has involved the definition of costs incurred by an efficient hospital. Since the passage of PPS, much of the debate over the adequacy of payment rates has focussed on the hospital's profit margin -- defined as revenue minus cost.

The problem with both of these standards is that costs are being used as the standard for comparison. If hospital costs continue to increase 2 to 4 percent above the hospital market basket every year and costs are used as the standard for setting hospital rates, the cost containment efforts will have limited effectiveness. The hospital industry will control the rate making process.

This can have significant implications for health care spending. For example, if hospital costs continue to increase at 3 percent above inflation for the next 25 years, the percent of the GNP spent on hospital care will double from the current 4.5 percent to 9.0 percent in 2015. By way of comparison we spent 6.4 percent of our GNP on education and 6.2 percent on national defense in 1988.

There are alternatives to using costs as the standard. Other countries establish hospital budgets without even calculating hospital costs. In most of these countries, the government negotiates with the hospital over the budget and the hospital learns to live within the budget. Unless we want the hospital industry to spend 9.0 percent of the GNP in twenty five years, we are going to have to learn from these other countries.

Cost containment can occur without damaging quality. Maryland implemented an all payor rate setting program in 1972. When the program was introduced, Maryland's hospital costs per capita were the 4th most expensive in the nation. In 1989, after 17 years of cost containment, Maryland was the 27th most expensive. It's hard to measure quality, but a recent ranking by academic physicians listed The Johns Hopkins Hospital as the best hospital in the nation and the second best health care system after the Mayo Clinic. Several weeks ago, I spoke to the Maryland Hospital Association and they still endorse all payor rate setting in Maryland as the best way to pay for uncompensated care in the absence of universal health insurance coverage.

I would be pleased to answer any questions.

Table 1

Hospital Characteristics

	1982	1989
Occupancy Rate	75.3%	66.1%
Full Time Equivalent Personnel Per Occupied Bed	4.3	5.3
Percent of Hospital Budget Spent on Capital	6.5%	8.7%
Profit Margin	5.0%	5.0%

Chairman **Stark**. Dr. Long.

STATEMENT OF HUGH W. LONG, PH.D., ASSOCIATE PROFESSOR, A.B. FREEMAN SCHOOL OF BUSINESS, TULANE UNIVERSITY, AND MEMBER, MEDICARE GEOGRAPHIC CLASSIFICATION REVIEW BOARD

Mr. **Long**. Thank you, Mr. Chairman. I appreciate very much the opportunity to share my views with the committee today. My general view of the position today of the health care industry, and hospitals in particular, is somewhere in between what I think one is going to hear from the administration and from the hospitals. It is my basic thought that hospitals are neither being generously overpaid nor horrendously underpaid, that if everyone is a little bit unhappy we must be fairly close to being at the right place.

I am concerned about some of the interpretations of the data that we have had, partly because I think there is tendency to look at the data—I have the same data that everyone else has—as though there is the capacity for instantaneous change within the industry and that we are dealing with a static set of relationships. And I think neither of those is true. At this point in the PPS experiment, if you would, one has to understand that we have not yet approached the half-life of the fixed assets which are typically characteristic of this industry. If everyone with perfect foresight building a hospital in the early 1980s had known what the future would bring, they might have built much smaller hospitals. Having that amount of capacity in place, it is very hard to unplug it overnight in addition to the institutional reality that downsizing is always a sticky process in that sort of adjustment.

Chairman **Stark**. It is my understanding that—and I want to see if you are saying the same thing—that the average life of the capital assets in the hospital system is around 7 years. Is that true?

Mr. **Long**. For the movable assets, it is less than that. For the buildings, of course, it may be as much as 20 years.

Chairman **Stark**. But the average is 7. Is that right?

Mr. **Long**. So we have been through a life cycle of the movables, but when you start talking about the square footage, where you have the beds, et cetera, you can, of course, adjust by not staffing them, but you cannot make the building go away in a short period of time. The other thing that we need to note is that the hospital, as we have grown up knowing it, is itself dramatically changing during the 1980s and currently. We are talking about the core business of hospitals, inpatient business shrinking significantly, and a major expansion on the outpatient side. In nominal terms, outpatient activity has more than tripled in the 1982 to 1989 period, and in real terms more than doubled while, by all of the normal and historical ways of looking at inpatient activity, we are seeing shrinkage. There are fewer patient days, fewer admissions, shorter lengths of stay and fewer expenditures for inpatient care as a percentage of gross national product, fewer real units of service, again in the traditional measures on a per capita basis.

This is true not only of Medicare but of the population at large. So that the overall picture is one in which, as Dr. Wilensky has pointed out, we have a small shrinkage in the number of institutions, in the number of beds, but it is not a wholesale decline in the number of institutions or an immediate threat to the survival of acute care. On the other hand, it is clear that the fiscal health of hospitals generally has been declining and certainly with the exception of teaching hospitals, I do not think anyone can claim that PPS is substantially enhancing the fiscal health of hospitals in the current decade.

As we have shrunk the inpatient side in the normal terms of activity, however, we have to understand that we have greatly increased the intensity of care on that side just as, incidentally, we have increased the intensity of care on the outpatient side as we have moved patients out of the hospital. Some of this is real. Some of it is illusory. As Dr. Altman has pointed out, not all of the case mix intensity increase is real. There is DRG creep in there. And he estimates between 35 and 40 percent of that may be illusory, but that means that the other 60 to 65 percent is quite real. And one has to understand that when one is looking at case mix intensity as an adjustment, that is only taking into account the front end of that activity, that is the fact that the persons being admitted to the hospital tend to be sicker.

To that, one has to add the fact that we are discharging patients sooner and, on the presumption that patients are less sick at their end of the length of stay than they were at the beginning, this also will increase the average intensity. Therefore, it is hardly surprising that we are using more resources in real terms per inpatient unit of service. For example, I part company with Dr. Anderson a little bit on the employee numbers. Although we have had a 25-percent increase in FTEs per occupied bed, this is based on raw numbers. We have only added 60,000 employees to community hospitals. That is less than a 2 percent increase on a 3.1 million base 1982 to 1989, only 60,000 additional employees, and those obviously have totally gone to support the increased outpatient activities. In addition, in the preexisting base, employees devoted to inpatient have also been shifted to outpatient.

And when I make the adjustment for the inpatient-outpatient mix, it seems to me that the FTE equivalents in real terms per occupied bed, the people who are delivering the inpatient care, has actually gone up only about 10 percent.

When you add to that the fact that we still have the differential incentive for capital intensity which has been discussed at length by previous witnesses—and we all agree those moneys need to be reallocated to establish a level playing field between capital and operating expenses—it is my sense that if that kind of an adjustment is made, if we provide a safety net for teaching institutions and rural hospitals, that basically we are pretty much on target in terms of providing a fiscal environment that is going to continue to lead to enhanced productivity.

The small gains that Dr. Anderson speaks about, in my mind are not bad news. I think that the hospital industry has been doing very well. Thank you. I would be happy to take any questions.

[The prepared statement follows:]

STATEMENT OF HUGH W. LONG, PH.D., ASSOCIATE PROFESSOR TULANE UNIVERSITY, AND MEMBER, MEDICARE GEOGRAPHIC CLASSIFICATION REVIEW BOARD

Mr. Chairman, members of the Committee, my name is Hugh Long. I am a professor of health care management on the faculty of Tulane University and am a member of the Medicare Geographic Classification Review Board. My testimony today reflects my own views and should not be construed as necessarily reflecting the views either of Tulane University or of the MGCRB.

U.S. hospitals have survived a decade of significant changes. These changes are of two types: changes in payment for and changes in monitoring of the care hospitals provide. Examples of payment changes include TEFRA, PPS, major growth in capitation and negotiated discounts. These have been accompanied by dramatic changes in monitoring, largely in the form of an increasingly intense overlay of managed care techniques, even within traditional indemnity insurance systems.

Notwithstanding these changes, hospitals are neither collapsing nor disappearing in any wholesale fashion (Tables 1a and 1b). On a net basis, approximately 94% of the number of institutions existing in 1982 are with us today. This rate of attrition of under one percent per year is less than one-fifth what many predicted in the face of the changes that have occurred. Hospitals are surviving.

Surviving for a hospital means at minimum surviving fiscally, i.e., meeting payrolls. Clearly, however, meeting payrolls is not the same thing as being fiscally healthy. And indeed, most indicators suggest that the fiscal health of hospitals is on the decline. (And this is especially true for rural and most teaching hospitals.)

For example, the private-sector Health Care Investment Analysts organization reported last month, based on its study of data from the Health Care Financing Administration, that nearly 15% of all hospitals are now financially distressed (reflecting cash flow and utilization problems), up from about 11.5% only three months earlier.

Deloitte and Touche's The Sourcebook: The Comparative Performance of U.S. Hospitals (Fourth Edition) reports overall hospital margins declined from about 5% in 1985 to less than 3.5% in 1989. Even a 5% overall margin would be inadequate in the long run to allow institutions to remain static relative to population growth and inflation, even without considering technology, all of which require anticipatory investment.

ProPAC has separately reported PPS margins for hospitals by PPS year which show an even more dramatic shrinkage, recently well below 2%. As Allen Dobson and Elizabeth Hoy noted in a 1988 article in Health Affairs, however, we should be more concerned with the trend in these numbers than in their absolute amounts because of the definitional debate over the appropriate margin formula. In addition, there remains the impossible task of trying to approximate economic reality through accounting allocations of overheads. Nonetheless, there is broad consensus that PPS is not enhancing most hospitals' fiscal health. The one exception to this, as ProPAC notes in its current report, is in teaching hospitals where the PPS margin significantly exceeds the overall margin. Nonetheless, teaching hospitals' overall margins remain generally poor.

Concurrent with this erosion of hospital's fiscal degrees of freedom, the basic institution we call a "hospital" is changing dramatically in real service terms. The payment and monitoring systems changes that have come into play during the past decade have resulted in a significant alteration of the traditional definition of the hospital as an acute care institution: inpatient activity is shrinking in both absolute and relative terms by all usual measures (admissions, patient days, dollar volume compared to population and overall economic activity) and outpatient activity is expanding in relative terms. (Tables 2a-2e)

Admissions have averaged a 2.2% decline per year during the 1982-1989 period and patient days have dropped even faster at a 3.7% annual rate, reflecting declining inpatient lengths of stay. On a per capita basis, admissions and patient days have shrunk even more rapidly at 3.5% and 5.3% annual rates, respectively. Even within the Medicare population, admissions have been reduced absolutely during this period with an annual per capita shrinkage of 2.6%, while patient days have dropped 2.4% per year overall and 5.6% per year on a per capita basis. These latter numbers are almost certainly attributable to the changed incentives of the Prospective Payment System.

As a share of GNP, community hospital inpatient revenues have declined almost three-quarters of a percentage point per year from 1982 through 1989, dropping from 3.2% to 3.0% of GNP during the period.

As inpatient activity has declined, however, that activity has become increasingly intense in resource use. The perennial nemesis of the health care industry is its inability to measure output definitively. It is this fact that continues to plague analysis of hospital productivity. A patient day in 1991 is clearly not the same thing as a patient day in 1982. But that difference is exceptionally difficult to measure empirically, and consequently, most researchers choose not to measure it at all.

Yet, I think we would all be appalled if the 1991 patient day did not require significantly more resources than the 1982 patient day.

The 1991 inpatient is sicker, by design. We affirmatively keep less-sick people out of the hospital by using managed care gatekeepers, second opinions, pre-admission certifications, etc., and move recovering people out of the hospital ever more quickly in response to the deliberate economic incentives of PPS and other payment mechanisms such as capitation. This latter is evidenced by utilization statistics (Tables 2a,2b,3a,3b).

The number of full-time equivalent employees per occupied bed in community hospitals has increased nearly 10% during the 1982-89 period, and when inpatient revenues are adjusted for inflation (using the AHA market basket), real resource use per patient day and per admission has increased 20.6% and 14.4%, respectively, during the period. (Tables 4a-4d)

These real increases are not surprising for two reasons, one of which I've already discussed, the fact that the inpatient census of hospitals is necessarily a sicker population. The second reason is the fact that we have continued to subsidize hospitals to maintain or increase capital intensity using capital cost passthroughs.

I am not suggesting that medical technology and nonmedical technology as used in hospitals is in any way undesirable or should be constrained per se. But I do suggest that by biasing hospitals' internal resource allocation decisions in favor of depreciable and/or leasable assets vis-a-vis substitutable operating expenses, the resulting capital intensity increase reflects not only the greater acuity of the average inpatient, but also the fact that we have continued to reward hospitals that substitute capital for labor and supplies.

Further, I note that, because of the way in which capital payments are defined, capital cost passthroughs have also contributed to the declining fiscal health of many hospitals by subsidizing debt financing.

I think it is clear that the likelihood of financial distress increases in direct relationship to leverage, the proportion of borrowed capital funds. Yet, the passthrough of interest expense makes debt appear cheaper to hospital borrowers. Indeed, in the short run, it is cheaper. But in the long run, even subsidized debt begins to bite the borrower when significant structural changes such as the decline in inpatient activity take place.

From the beginning of PPS, it was the stated intent of Congress to end capital reimbursement on a retrospective cost basis. And from the beginning, hospitals have successfully resisted that change because of their fear of the pain of being weaned from the 1966 system. I concur with HCFA and with ProPAC that the weaning must begin as soon as possible, in fulfillment of the intent of the 1983 PPS legislation.

In the meantime, however, we must not attempt to punish hospitals for having responded to the incentives they were given, nor should hospitals be lumped in with other sectors of the health care industry as aggregate health care costs surge past 12% of GNP. Fundamentally, the hospital as most of us fondly remember it, the community inpatient institution, is on the wane. Even as health care continues to be a major growth sector of the economy, the core business of the community hospital is both shrinking in volume and intensifying in resource use. I see no evidence of lack of efficiency or of lack of productivity as those processes proceed apace, and therefore no need to constrain further inpatient payment except to the extent that capital cost passthroughs need to be reallocated, and continuing attention needs to be focused on rural hospitals and on teaching hospitals whose fiscal health remains less good than that of others.

Table 1a.

Total Community Hospitals

Operating in Calendar Years

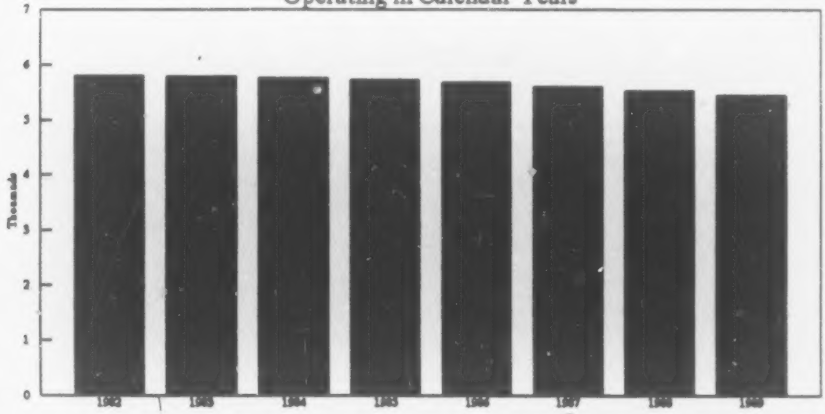


Table 1b.

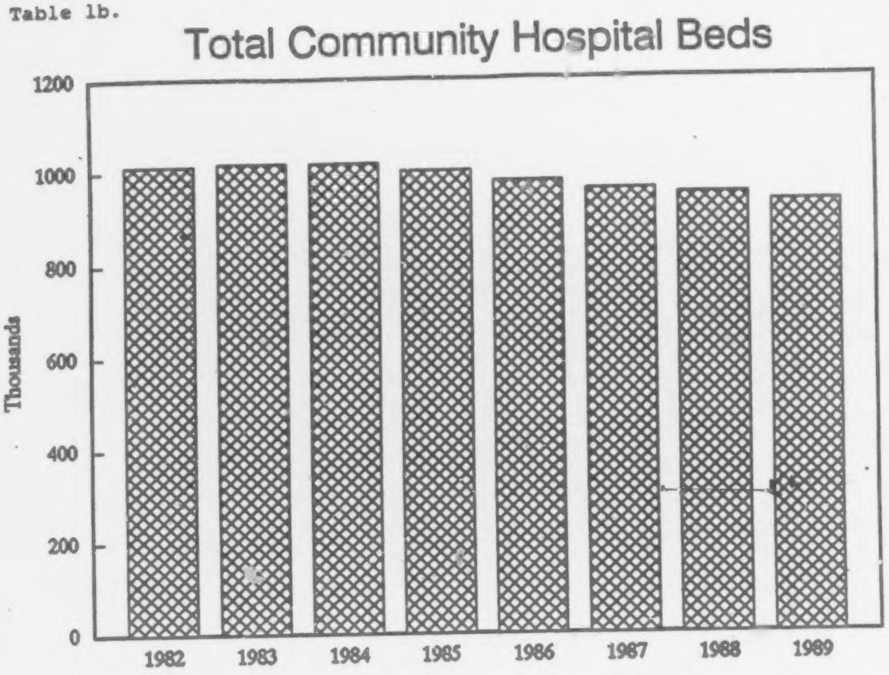


Table 2a.

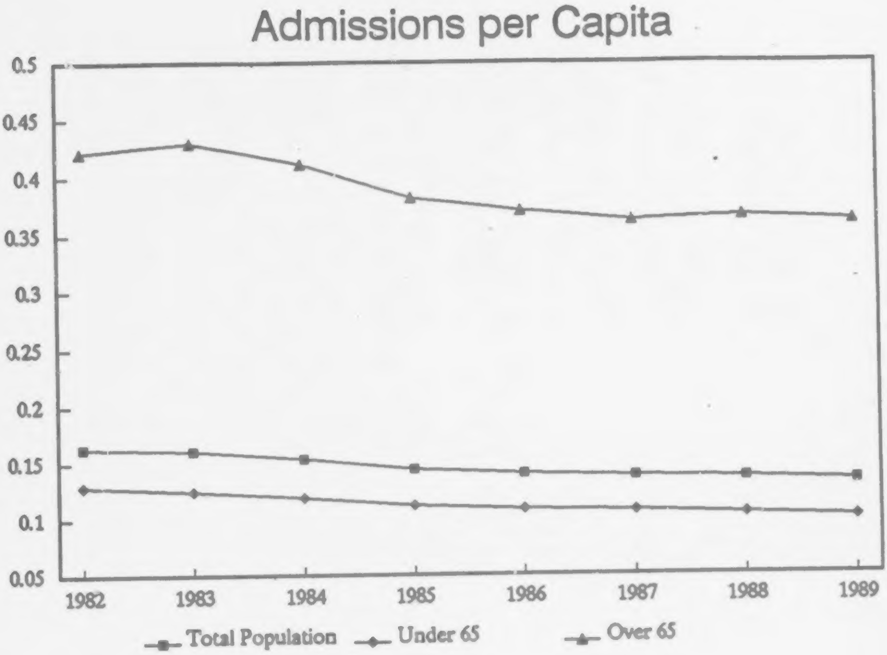


Table 2b.

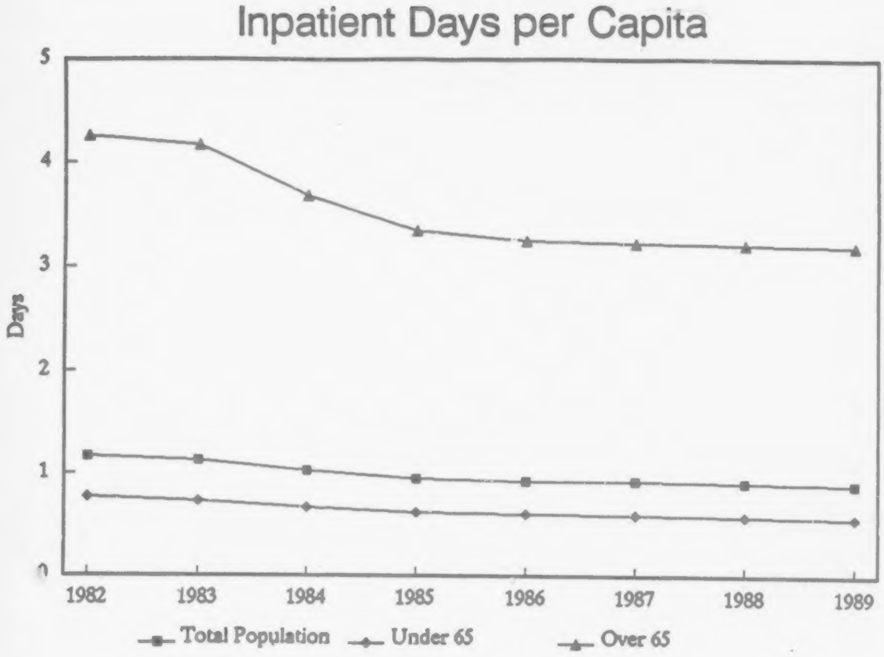


Table 2c.

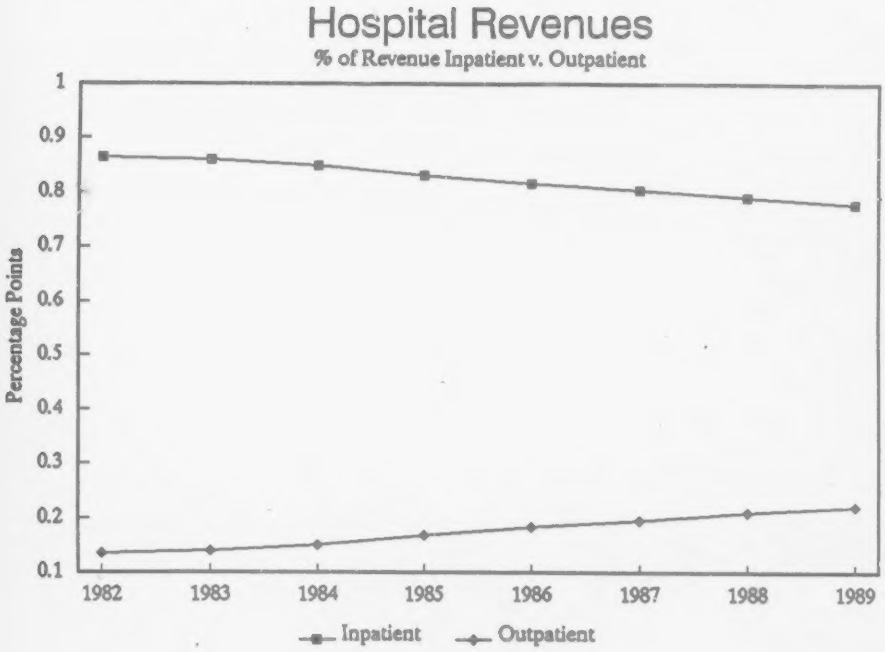


Table 2d.

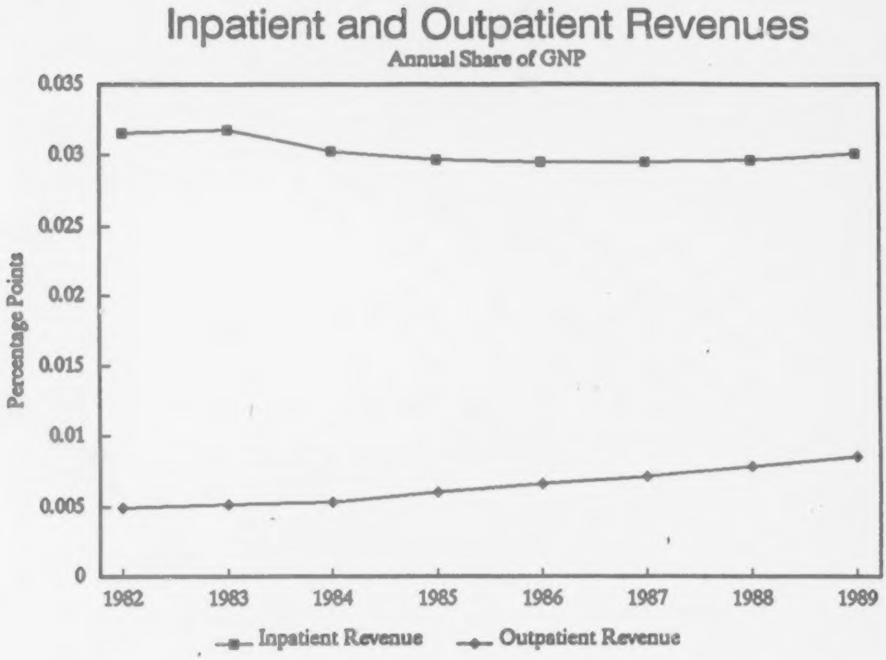


Table 2e.

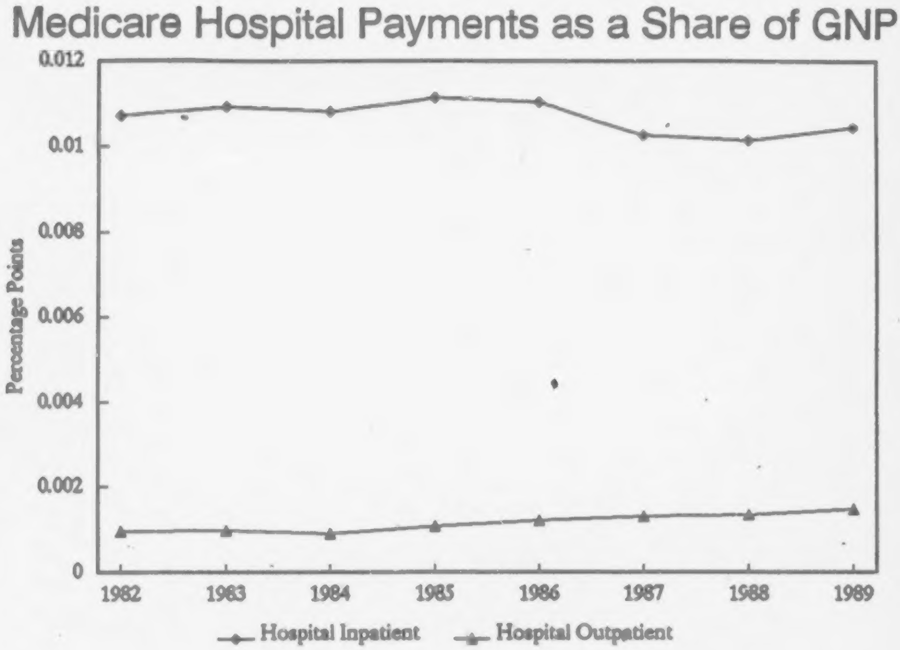


Table 3a.

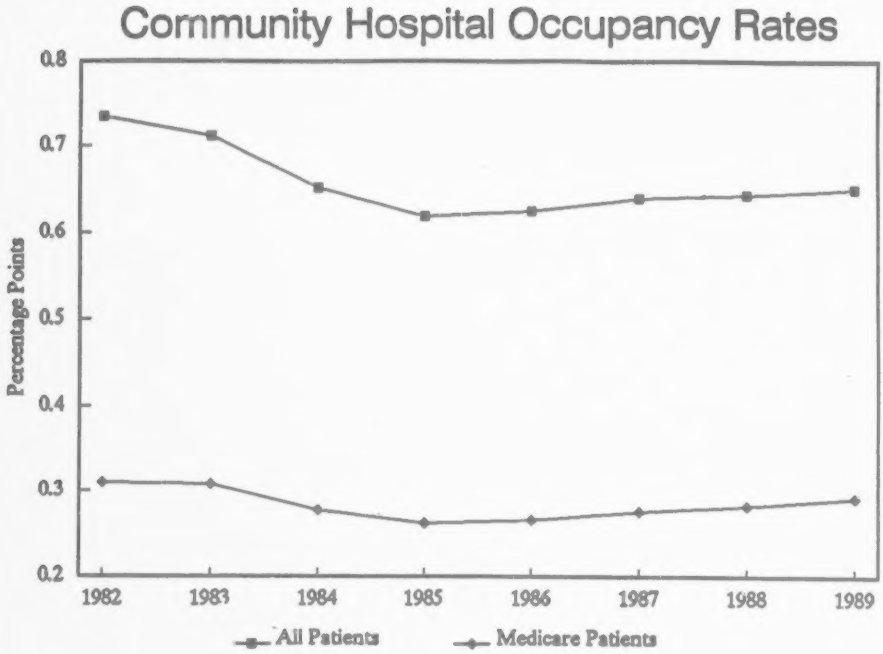


Table 3b.

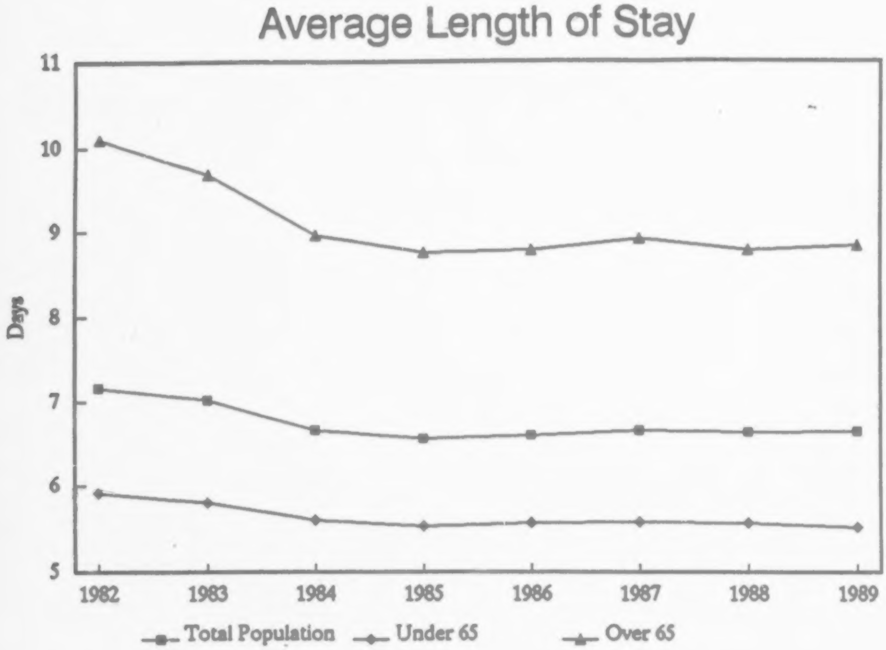


Table 4a.

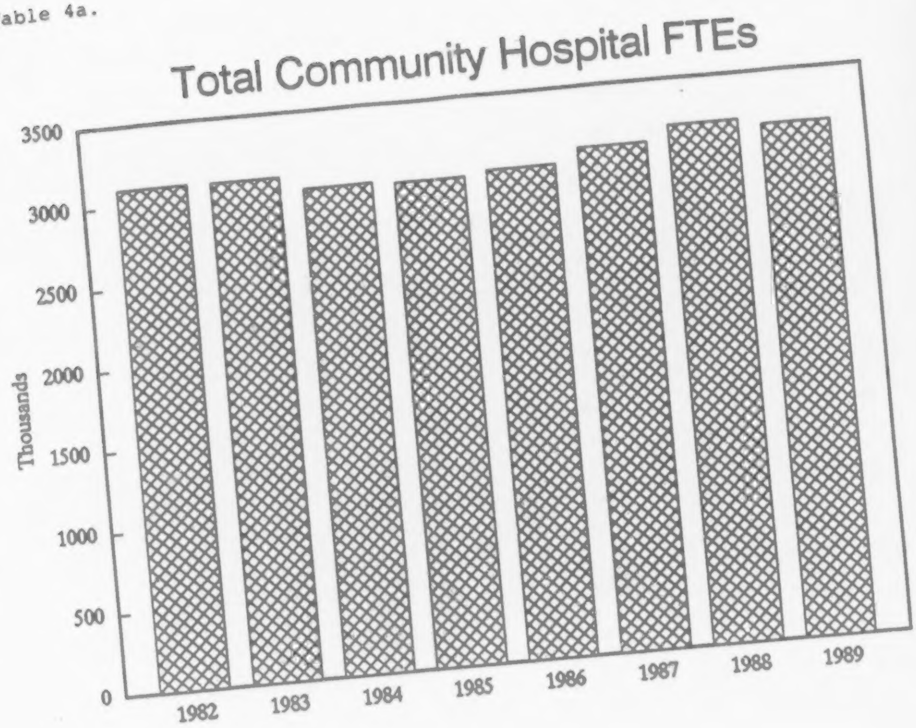


Table 4b.

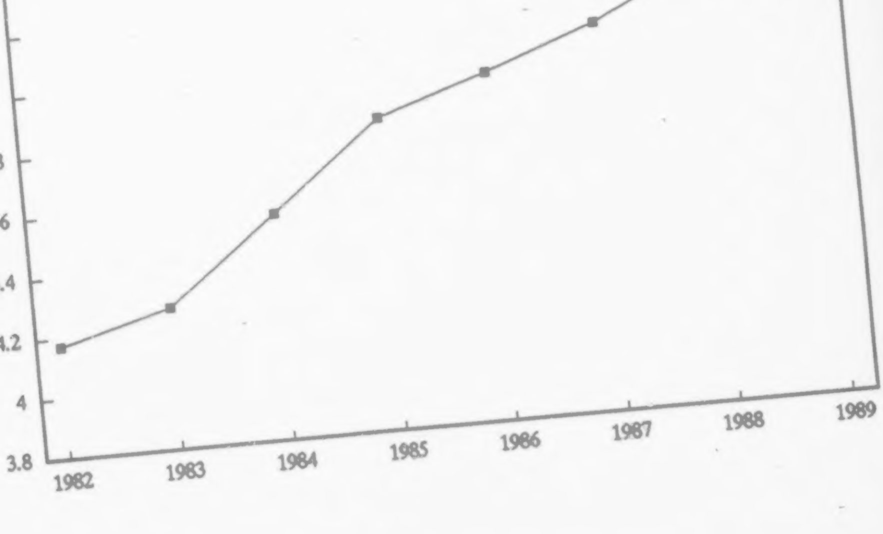


Table 4c.

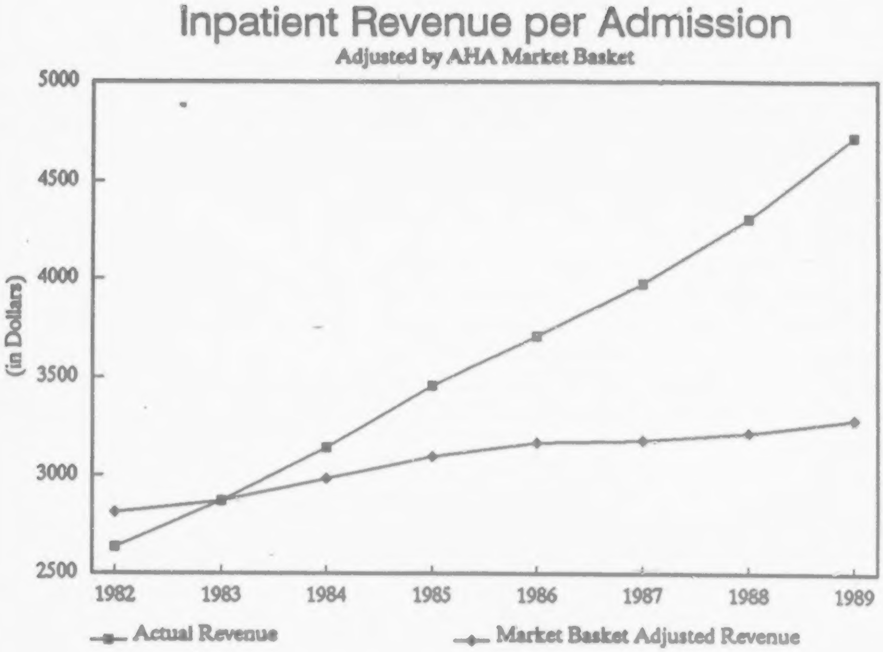
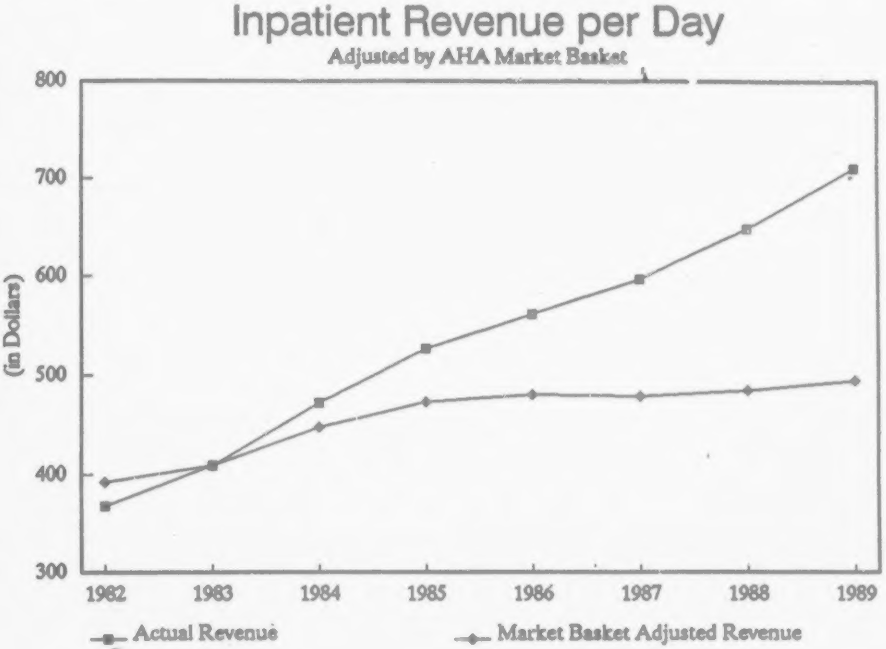


Table 4d.



Chairman **Stark**. Mrs. Johnson.

Mrs. **Johnson**. My experience of my hospitals, Dr. Long, substantiates your testimony, and I just wonder how good is our data? I am pleased that you have data that gives us more insight into employment patterns, and what services they are associated with. On this issue of sicker patients, who is using the system, do we have clear data on that? I mean I have a lot of anecdotal data as I go from hospital to hospital, but what does the data tell us about who is actually going into hospitals? When you say they are being discharged earlier, and, of course, Congress has put in place some very powerful discharge planning requirements that increase costs, what can you tell us about the costs of the fact that we are discharging quicker?

Mr. **Long**. Well, if you mean system costs, clearly the earlier discharges from hospital inpatient settings are not a free good.

Mrs. **Johnson**. And do we have any figures that show how much those costs have grown associated with the early discharges as opposed to outpatient in general? Do we have any information on the growth in home care and outpatient costs as a consequence of our change in hospital discharge policy?

Mr. **Long**. I do not think we have any studies that I am aware of that make that specific classification. Clearly, a lot of home health care growth has been attributed to the earlier discharges. Clearly, families as well as skilled nursing facilities, as well as home health care facilities, are providing services that used to be provided during that last 2 or 3 days that Medicare patients used to be in the hospital. But I have not seen a study that would say of all outpatient activity, this much is the shift from A to B because PPS squeezed on the A end of the balloon.

Mrs. **Johnson**. So, in a sense, in talking about the productivity of the system, we do not know what those costs are or what they would have been if we had kept them in the hospital. Therefore, we do not know what we want have accomplished, in a sense?

Mr. **Long**. That is true, although I think there would be general agreement that the care which is provided outside of the hospital at the end of a length of stay is less expensive than doing it in the hospital.

Mrs. **Johnson**. Well, certainly. And as to intensity, degree of illness, entering the hospital?

Mr. **Long**. Well, here, again, we have a real difficulty in measuring carefully, and that is what Dr. Altman was testifying to. When you talk about the case mix intensity having gone up substantially, it is difficult to separate the part of that which is DRG creep or upcoding from the real amount, although we know that that number in gross terms is up about 25 percent.

Mrs. **Johnson**. Anecdotally, as I visit my hospitals, people will say to me the people who are in the intensive care unit now are people who 5 years ago would have died, and the people on the floor are people who 5 years ago would have been in intensive care unit. Now this is a rather old example so maybe my number of years are not right. But we do know that there are a lot of people that are now in the intensive care unit who very recently would have been seen as terminal, and that there are a lot of people on the floor who not so long ago would have been intensive care unit.

And it seems like we ought to be able to get a better grasp on this aspect of what is driving costs.

In other words, is quality driving costs or is new options to life saving and health restoring driving costs, and what percentage of each? We are really hampered by not knowing that because then when your colleague, Dr. Anderson, says, look, we have only made this little bit of progress, well, if the institution were doing the same thing, one could say, yes, that not is productivity. But if the institution is, in fact, making a different product, so to speak, servicing a different group, then I am not sure that you can say that is all we have accomplished. And so to me, this is one of the problems for the public, too.

They think that costs are going up for the same product, and we are not able to say that costs for the old product have gone down *x* amount. But there is a new product out there on the market, and the costs of that are doing such and such to the system. So I think this issue of intensity there has got to be some information out there somewhere because certainly everybody in the system knows what they are doing about or says that this is a materially different situation. You are welcome to comment.

Mr. ANDERSON. I think that the case mix index, if you believe the DRGs are an adequate measure of output, has gone up about 25 percent since the implementation of PPS. And we think that about 60 to 70 percent of that is real, and about 30 percent of that is not necessarily real. So that is maybe a 15 to 18 percent growth in intensity of service.

Mrs. JOHNSON. But the case mix index while it reflects intensity of service does not reflect, in a sense, the options of care. For example, it does not reflect the fact that there is a treatment modality that is now available that is 5 times as expensive but 85 times as effective or something, you know. And so just case mix does not tell you what I need to know. Do you see that?

Mr. ANDERSON. I understand. It is unfortunately the best measure that we have, and if we look at mortality rates over the period of time, they are not substantially different, both in hospital mortality rates and, probably much more important, 30 day mortality rate postdischarge or postadmission. This is really what matters, keeping those people alive.

Mrs. JOHNSON. Do you have those mortality rates as a function of age?

Mr. ANDERSON. Those are available from the Health Care Financing Administration. Basically they do not show——

Mrs. JOHNSON. The age has gone up, but the——

Mr. ANDERSON. Age has gone up a little bit, 1 percent a year approximately. But basically we do not see a substantial change in mortality since PPS.

The RAND Corp. did, to follow up on one of your questions, did a study of postdischarge outcome, using Medicare data. A study at the University at Minnesota is collecting much more detailed data to follow up on this activity. And we did one at Johns Hopkins as well. They all show a dramatic increase in home health agency utilization and skilled nursing home admissions.

The question is whether an increase is appropriate? What did we gain from those last 1 or 2 days of hospital care. If you look at 30 day mortality, it does not appear that we have lost anything by discharging people one or two days earlier and sending them to skilled nursing homes or sending them to home health agencies, as long as they are able to receive that care, and that is the real problem, making sure that they can receive adequate postdischarge care. It is a very difficult thing to do to arrange that care once you leave the hospital. Even for somebody who has an ability to pay, it is very difficult to arrange.

Mrs. JOHNSON. I do not disagree with that. Just in terms of global costs, you cannot ignore the fact that you have those follow-on costs that used to be in the hospital that are now elsewhere and they are less, and they are better, and I agree with that.

Mr. ANDERSON. Right.

Mrs. JOHNSON. But factoring it in, I think, is still a problem, and thank you.

Mr. LONG. If I might, just to emphasize one point. The fact that we do have that earlier discharge is not captured in the case mix intensity numbers, even though it, in fact, raises the average level of acuity of the patients who are in the hospital.

Mrs. JOHNSON. And the average daily costs.

Mr. LONG. Yes, ma'am.

Mrs. JOHNSON. Thank you.

Chairman STARK. Mr. Gradison.

Mr. GRADISON. Thank you, Mr. Chairman. Our focus here largely is on hospital costs, but there are some references, as well, to the share of GNP which is going to hospitals. I had the impression prior to this hearing that the percentage of GNP going to hospitals had not changed much over the years. Dr. Long says on page 2, and reading this, as a share of GNP, community hospital inpatient revenues have declined almost three-quarters of a percentage point per year from 1982 through 1989, dropping from 3.2 percent to 3 percent of GNP during the period.

Now, I mention that as background to inquire of Dr. Anderson what you meant in your final page when you said unless we want the hospital industry to spend 9 percent of the GNP in 25 years, we are going to have to learn from these other countries, other countries having constrained hospital costs better than we had. What is the problem?

Mr. ANDERSON. Well, I begin with a slightly different percent of GNP, and it is 4.5 percent. If you say that hospital costs are going to increase 3 percentage points per year faster than the overall economy, after 25 years, that means that you will double, as a percentage of the gross national product, the percent of the expenditures on hospital care. They will go from 4.5 to 9 percent, and that is simply the impact of compound growth of 3 percent per year for 25 years.

And what that means is that we will spend 9 percent of our gross national product on hospital care and unfortunately if we do not change the amount that we spend on education. We will still spend 6 percent of our gross national product on education.

Mr. GRADISON. So the percentage of GNP being devoted to hospitals may not have been going up a lot recently, but it could. Is that what you are saying?

Mr. ANDERSON. I think it has gone up at about the same rate as the overall health care has grown up as a percent of GNP. Hospitals have remained between 39 and 40 percent of total health care spending. And that is true in 1980 and it is true in 1990, and so it has got to go up at exactly the same rate.

Mr. GRADISON. And I can tell from some nods of heads there is some disagreement about what the numbers show, and it does not let the hospitals off the hook to say their GNP share is constant or going down. It still is a question of whether it is too high or too low.

Mr. LONG. Well, Mr. Gradison, I would point out that there clearly is a difference between overall expenditures for everything in what we call a hospital vis-a-vis inpatient expenditures and the point I was making in my testimony is the inpatient activity of hospitals is a declining share of GNP during the last decade. Overall hospitals have been creeping up slightly relative to GNP once you add in the outpatient side.

Mr. GRADISON. Outpatient side, right.

Mr. LONG. The other thing, however, is that as a proportion of national health expenditures, hospitals have declined during the decade of the 1980s. I think they were 38.6 percent of total outlays in 1989, compared to about 42 percent in 1980. And if you look at the national health expenditure data, that percentage point shift has exactly been taken up by physicians if you look at their shift in the distribution.

Mr. GRADISON. Well, they are not here today so we can talk about them. I was struck by the difference between Dr. Wilensky and you, Dr. Long, in her comments and your comments about the question of the actual level of hospital costs. Dr. Wilensky, in effect, said, that, well, I read it to you. She said we all need to develop a better understanding of the reason for increasing costs. And at other points in her testimony, she gave me the impression that we really do not know why these costs are going up so high. But they are going up too fast because she said that we, and coming back to her testimony again, she said the Federal Government simply cannot afford to continue to pay for costs increasing at double the rate of inflation.

OK. Now you come along, and you say—I am not trying to take this out of context, and if I am, I know you will correct me. You said I see no evidence of lack of efficiency or of a lack of productivity as those processes proceed apace and, therefore, no need to constrain further inpatient payment except to the extent that capital costs passthroughs need to be reallocated and so forth. Now, there is a difference here; right?

Mr. LONG. Yes, sir, there is.

Mr. GRADISON. OK. Could you talk a little bit about that difference because it is fundamental to why we are here this morning, this evening, whenever it is. There are no windows. You sort of lose track.

Mr. LONG. There are two thrusts there that I would comment on. The first is that I think the Health Care Financing Administration does have a basic understanding of why hospital costs, in particular, are going up. And it is, of course, from their point of view both a combination of inpatient and outpatient activities. And I think the difficulty that we all have is being able, as Dr. Altman pointed out, to measure with any degree of accuracy the various components of that cost, and more importantly, to be able to relate that to a defined unit of output. I mean if you want to talk about efficiency or productivity, you have to have an output measure that we can all agree upon, and that we can empirically observe and replicate, and that has been the perennial problem with health care is how do you define the output. It is not a patient day or a DRG–127 discharge. It is something much more than that.

It is the difference in the status of the patient at admission versus discharge. We do not know how to measure that very well. We are making some steps at that. The case mix index is one step. Adjusting it for DRG creep is a different step. Figuring out how to deal with earlier discharge is yet a third problem. So we are really at a very primitive stage, I think, in our ability in an econometric sense to define efficiency and productivity. And so when I say I do not see evidence of inefficiency, that does not mean that I am alleging that we have efficiency. I do not know because I cannot measure it, and I do not think anybody else can either.

Mr. **Gradison**. OK. I understand. We are spending more and enjoying it less. That is what it amounts to. Thank you, Mr. Chairman. I also wanted to note with appreciation, Dr. Long, your assistance to our former colleague, Henson Moore, on some activities some years ago. Your continuing efforts to assist us in understanding these issues is very much appreciated.

Mr. **Long**. Thank you.

Chairman **Stark**. Thank you. If I could kind of summarize, Dr. Long, you are not sure that productivity has gone or up down, but your best guess is that at best it is flat. And Dr. Anderson would probably say productivity has gone up as much as it should. Is that correct?

Mr. **Anderson**. It is not as much as I think we had anticipated or hoped for when PPS was passed.

Chairman **Stark**. Nor as much as the ship industry, for instance, where productivity may have gone up higher, or fast food.

Mr. **Anderson**. Overall, industry tends to go up around 2 or 3 percent per year.

Chairman **Stark**. With all the questions of outpatient, inpatient, and so forth, how would you both grade the industry in terms of adjusting to change or restructuring? Have they done a good job, fair, or poor?

Mr. **Long**. I think I would give them a B minus.

Chairman **Stark**. Dr. Anderson.

Mr. **Anderson**. I think in certain areas they have adjusted very well in moving toward outpatient care. Much of it was mandated on them by coverage policies, so they were forced to do it, but they have certainly adjusted and adjusted very well to it. I think the one area that they have not adjusted very well is downsizing their inpatient facilities, and I recognize that it takes awhile, but we are talking about beds set up and staffed, not beds that could be mothballed.

Chairman **Stark**. Dr. Long, are they efficient in their use of resources? I mean that is what you were just referring to?

Mr. Long. As an industry, first of all, I do not believe that hospitals were grossly inefficient in a narrow sense pre-PPS in the sense that I think they produced laboratory tests and imaging diagnoses efficiently.

Chairman Stark. As well as the next guy or as well as could be expected?

Mr. Long. As well as could be expected given the technological state of the world. The issue of efficiency was the quantity of those various line items individually efficiently produced that were being applied to an episode of care relative to the outcome. That is the area in which I think we all had fairly high expectations when prospective payment came in place, and I think that is where the expectations have tended to be somewhat disappointed although there is a clear economic incentive to move in that direction, and I believe hospitals have moved in that direction. We may have been overly optimistic in 1983 when we were putting this together.

I agree that there could have been, I think, an improved performance in some of the reduction of staffing in the short-term, but as I indicated earlier, it takes awhile until you are the end of the life cycle of your existing assets to literally downsize. There are a lot of inefficiencies that are carried forward.

Chairman Stark. So that is an area where you two come perhaps closest in your analysis. I keep talking about occupancy, but I am not sure that is a word. The hospital association changes the definition on me, and then I get——

Mr. Long. Well, I have real trouble with the notion of occupancy as a measure of efficiency in any event. 85 percent occupancy used to be the definition of full, but I am not sure it was ever the definition of efficient.

Chairman Stark. OK. What can the hospital administrators do? I am not particularly talking here either about cutting costs because I suspect they all try to do that as well as they think they can, or increasing their share of the markets, which unfortunately is just transferred. I do not think they can increase demand in a community. Maybe technology does that. But if you do that you are just stealing, as an industry, you are just stealing the other guy's patients, it would seem to me, and that does not help us in the aggregate any.

Is there much that the hospital administrator can do assuming that the State has certain requirements, the medical profession has certain requirements, we have certain requirements, the unions if they are in an organized area have certain requirements? It seems to me that the administrator is just steering a horse on a merry-go-round. What is left for them to do?

Mr. Long. Well, it would seem to me that the degrees of freedom that the chief executive officer of an institution has in an operational sense are, indeed, relatively limited, as you suggest.

Chairman Stark. Right. He can close the emergency room if they will let him get away with it in the community because that is a loser. But that is, in an operational sense, is exactly what I——

Mr. Long. But I think that there are major opportunities available in the strategic sense. And I think the opportunities for the acute care institution in terms of building new alliances with the physician community and merging the interests of physicians with the interests of——

Chairman **Stark**. You did not mean ownership joint ventures; did you?

Mr. **Long**. Did I say that?

Chairman **Stark**. No. I did not think so. But there is a new name for that every month, and I just wondered what you——

Mr. **Long**. But I think there are legitimate opportunities there to bring the economic interests of various provider parties together and that that, in turn, can produce greater efficiency.

Chairman **Stark**. Does that not have to be done with some more resource allocation controls for the entire community to benefit? What is happening in my State where there is basically no control, the highest costs, and the least occupancy, and it all sounds bad to me, is that my inner-city hospitals, which are generally owned by the public and supported by them, are suffering and there are hospitals out in the suburbs beating each other's brains out and all running about 40 percent occupied and all building more rooms for MRIs than they can possibly use, and there is no coordination. Now they say, goodness, that is socialism, and I say, well, OK, in New York we call it regulation, and in Maryland they all get along very well with some regulation, as Dr. Anderson knows.

I guess my question is does there not have to be some coordination for what you just suggested, Dr. Long, to work? I mean to have these executives get together and best utilize resources or provide a consortium, you got to keep everybody at the table. Is that it?

Mr. **Long**. Well, clearly where one wants to end up is, I think, not in debate. The issue of the process of getting there, I think, is obviously the philosophical issue of whether you want to get there with governmental intervention, certificate of need kinds of programs, direct regulatory controls, or whether you believe that if we allow the system to play out over a reasonable period of time that a more competitive marketplace will eventually work its will, and the over capacity will ultimately disappear as the weaker players fail to survive.

Chairman **Stark**. If we are willing to let them, though.

Mr. **Long**. Then we get into that political question.

Chairman **Stark**. If I give you this one other thing. If politically, whether it is the Federal Government or the city or the State or the county, if they are for political reasons unwilling to allow the weakest to fail, then we have to have some other regulation. Is that fair?

Mr. **Long**. I would concur.

Chairman **Stark**. OK.

Mr. **Gradison**. Would you yield, Mr. Chairman, because I was intrigued by the statement made.

Chairman **Stark**. Sure.

Mr. **Gradison**. I forget now. The testimony—pardon me—in Dr. Anderson's testimony, he said research on individual hospital behavior by Judy Feder and Jack Hadley had suggested that only hospitals which have changed their behavior were hospitals facing financial problems—which is probably true. I mean maybe the answer is shock therapy of some kind. But the difficulty, as I see it, is that those that are forced to close—this is going to sound very socialistic—but may be the wrong ones. That is to say that the fact that they are forced to close does not mean that they are not providing a needed and useful service. It may be that they just have a higher proportion of people who cannot pay their bills and they are bankrupt. The hospital is bankrupt financially but not bankrupt in terms of its care for the community. I do not know how to cut through that one.

Mr. ANDERSON. No, I think——

Chairman STARK. Dr. Anderson, why do you not finish up because I have been——

Mr. ANDERSON. I think that the hospitals which many times are the most efficient hospitals are the inner-city hospitals and especially those hospitals which are in financial difficulty. They are incredibly efficient providers of care. Part of the reason why they are so different is that in order to survive, they had to become efficient, whereas some of the other hospitals do not have to become efficient because they still have a little bit of financial slack in them. And so that is what forces them to do it.

To answer your question about how can hospitals improve productivity, I think it is primarily by working with the physicians. The major change that PPS has brought about is the 1- to 2-day decline in average length of stay, and by working with the physicians, hospitals were able to do it. But if you look at how medical practice occurs in the United States, and you compare one hospital to another, for an identical type of service, you will see that in one hospital the average number of inpatient tests is 10. In other hospital it is five. And that is for an identical service for an identical type of DRG. And you have got to start eliminating a lot of that variation.

So when I go in and do comparative analyses, and the hospitals are starting to do this themselves, mostly the major teaching hospitals are starting to do it. They are starting to look at best demonstrated practice, and they are starting to say why do we do twice as many lab tests for this type of patient as somebody else. Their physicians get together and they say, well, we really do not need that to do that. It is the physicians working together within the hospital that will generate cost containment. What is going to push them to do that are financial constraints. If they have the money it is not a fun thing to do, and it is not something that they would want to do. But it is something if we are going to control health care costs, it has got to be done.

Chairman STARK. I agree. Thank you, both, for your interest in our problems and your assistance. It is appreciated very much.

Our next witnesses are a panel consisting of the American Hospital Association represented by our good friend, Paul Rettig, who is the executive vice president; the National Association of Public Hospitals represented by Larry Gage, president of the association; the National Rural Health Association is represented by its executive director, Robert Van Hook; and the National Council of Community Hospitals have sent their president, John Horty. Gentlemen, welcome. I will let you start out in the order that I called upon you. We have your written testimony. As you know, it will appear in the record in its entirety along with whatever supplemental or explanatory comments you would like to make. Paul, why do you not lead off?

STATEMENT OF PAUL RETTIG, EXECUTIVE VICE PRESIDENT, AMERICAN HOSPITAL ASSOCIATION

Mr. RETTIG. Thank you, Mr. Chairman. I appreciate the opportunity to present the views on behalf of some 5,500 members hospitals of the AHA. Just to follow on some discussion we just had, there is attached as chart number 1 to my prepared statement a visual presentation of hospital costs as a percentage of the GNP compared with other health care costs and total costs as a percentage of the GNP, which clarifies that hospital costs, both inpatient and outpatient expressed that way have been flat while the other categories have been rising.

I remember a day at the beginning of the Medicare program when cost reimbursement was thought to be the enlightened form of payment, and the administration when it tried to figure out what reasonable cost really was relied heavily on the American Hospital Association principles of reimbursement. And I might say those were the days. In those days, too, it was clear that Medicare was absolutely not to interfere with or influence the operation of any health care facility or influence anything in the health care system. And we have all moved a long way from that point.

Hospitals themselves have been willing participants in the development of prospective payment and have responded positively to the incentives under that system but nonetheless now find themselves in precarious financial condition. In addition to Medicare, Medicaid payment shortfalls and unsponsored or uncompensated care, as has been discussed today, are an increasingly significant source of financial difficulty for hospitals. On top of that, the President's proposed budget cuts, especially the cuts in indirect medical education, would only exacerbate the situation. We want to applaud the subcommittee's and its chairman's determination to hold to the position that a deal is a deal with regard to the 5-year budget agreement. And also to express thanks for efforts on behalf of adequate administrative funds in the Medicare program when OMB was not releasing contingency funds for that purpose.

We are looking still to dangers, as we see it, under the pay as you go budget rules where our concern is that people may seize on the administration's proposed budget cuts as a way to finance other desirable changes and we are not convinced that Medicare should be used in that way or that dedicated trust fund money should, in fact, be used that way. We do feel, as has been expressed today, that many of the specific problems we have tried to address on a day to day basis might better be addressed in the context of broad health care reform. So we like others are trying to think about that and think how the health care system should change. We are going through an effort to do that—a more or less year-long effort within the hospital community—and we hope to be able to talk to you about that in the future.

We appreciate your efforts to work with us as we adapted to the PPS system to make changes in such things as the urban/rural differential, and protection of indirect medical education, and so forth. We still see some technical problems in the PPS system in areas such as the definition of the market basket and in regard to things like the area wage index. We recognize that the medical geographic classification review board is perhaps a partial solution to problems in the area wage index area although we note with some concern that there is no provision for handling claims that have not been adjudicated by the March 31 deadline. It appears to us the deadline may not be fully met.

More concern with the PPS system is that it has turned out to be largely budget driven, and decisions that are not health policy driven have had to be made. A few figures—you have many—margin figures show that aggregate net patient margin was negative in fiscal year 1990. That is, hospitals lost money on the care of patients; and negative total margins exist for some 20 percent of hospitals—that is counting money from all sources, not just patient care revenues. Medicare margins have been increasingly worse, and we project that by fiscal year 1992 aggregate Medicare PPS operating margins may be between negative 10 percent and negative 15 percent. For the first time, payment shortfalls in Medicaid are becoming of increasing concern, outweighing the traditional concerns we have had about unsponsored or uncompensated care. Medicaid payment shortfalls are becoming a serious part of that problem for hospitals with significant numbers of Medicaid patients.

Although the financial situation of hospitals generally is a bit shaky now, hospitals are continuing to try to serve communities. We are participating, for example, in Healthy People 2000, if I have got the name right, a Public Health Service initiative aimed at promotion of preventive health care services; and hospitals in other ways are attempting to serve their communities. They are limited, as you have heard, by concern about overall financial ability to do so. Our Catholic hospital friends have a saying, I believe, that says "no money, no mission." And so we are struggling with that kind of thing throughout the hospital community. That concludes my statement. We appreciate the efforts of the committee and we look forward to working with you both on these specific problems and the broad topic of health care reform. Thank you.

[The prepared statement follows:]

American Hospital Association

AHA

Capitol Place, Building #3
50 F Street, N.W.
Suite 1100
Washington, D.C. 20001
Telephone 202 638-1100
FAX NO 202 626-2345

Statement
of the
American Hospital Association
Before the
Subcommittee on Health
of the
Committee on Ways and Means
of the
United States House of Representatives
on
the Status of Health Care
and Funding Issues for Fiscal Year 1992

February 27, 1991

SUMMARY

Health care and the future of hospitals in the United States are at a crossroads. Hospitals have responded positively to the incentives of the Medicare Prospective Payment System (PPS) and yet are in precarious financial condition.

For Fiscal Year 1992, AHA projects that the aggregate Medicare PPS operating margin will be between negative 10 percent and negative 15 percent. Medicaid payment shortfalls and unsponsored care losses are an increasingly significant source of financial difficulty for hospitals.

The President's proposed budget cuts--particularly the deep and unwarranted cuts in the indirect medical education adjustment--would only serve to further exacerbate this situation, thus highlighting the need for system-wide reform.

Further danger lies in the new pay-as-you-go budget rules, under which hospitals remain vulnerable, and which we urge the Ways and Means Committee to monitor closely.

Mr. Chairman, my name is Paul Rettig, executive vice president of the American Hospital Association (AHA) and director of its Washington Office. On behalf of AHA's nearly 5,500 member hospitals, I am pleased to testify on the status of health care and hospitals in the United States and on funding issues for Fiscal Year 1992.

Health care and the future of hospitals in the United States are at a crossroads. In the past decade, spending for health care has more than doubled. Our nation now spends over 11 percent of its gross national product (GNP) on health care services and research. While restraint has been shown in some sectors of the health care market, costs in other sectors have continued to spiral. Since 1982, spending for hospital care--both inpatient and outpatient--has grown more slowly than spending in any other category of health care expenditures. (See Chart 1)

Even though hospital spending has remained a constant percentage of GNP, hospitals are experiencing financial pressures. These financial difficulties are compounded by the growing federal budget deficit and trillion dollar plus national debt. Current estimates suggest a FY 1991 deficit of over $318 billion, depending on the ultimate costs of our military efforts in the Middle East. Policymakers are trying to control Medicare and Medicaid spending.

Employers are battling rising health benefit costs. Similarly, consumers' concerns about rising health care costs continue to grow while the costs associated with and the lack of access for the 33 million Americans without health insurance affects everyone. All of these participants--consumers, hospitals, physicians, business, insurers, and the federal government--have expressed dissatisfaction with the current health care delivery system, particularly with the way in which health care services are financed.

The current health care system is a jumble of individual programs that have evolved by default, not by design. The "quick fix" approach has contributed to the fragmentation of health care services. Similarly, budget-driven decisions produce health care policy that not only ignores the need for reform but also redistributes health care resources in a haphazard fashion and discriminates against the financially weak on the basis of their financial situation. Furthermore, maintaining the solvency of the Medicare Trust Fund and its commitment to beneficiaries cannot be ensured solely by extracting savings from providers. Any effort to resolve the problems of the health care system must be developed in the broad context of system-wide reforms.

This nation needs to move toward broad reform of our health care system. We need to redirect current financial incentives and to clarify our health care goals. AHA has been working with hospitals and others to broaden the discussion and debate on future reform of the health care system. We have been working toward the development of proposals to significantly improve the U.S. health care system by the year 2000. Preliminary outlines of our plan include universal coverage, catastrophic protection, and a realignment of provider incentives. AHA looks forward to bringing this plan to the table and sharing our thoughts on health care system reform with you in the near future. While AHA is looking ahead toward reform of the health care system, we are haunted by the promise and failure of past efforts. The hospital industry was a willing partner in the most recent effort to reform its portion of the health care system. The prospective payment system has not only yielded significant budget savings, thus extending the life of the hospital insurance trust fund, but it also has led to improvements in the efficiency of health care delivery. Hospitals have responded to PPS incentives by reducing the average length of stay; increasing the productivity of their staffs, hospitals' most costly resource; and, when appropriate, shifting an increasing proportion of care to the outpatient department, often the most efficient and cost-effective setting. (See Chart 2) Furthermore, hospitals have continued to meet the needs of their communities, providing state-of-the-art care, training health care professionals, and caring for the poor.

We appreciate the subcommittee's willingness to work with us as we adapted to PPS, to make adjustments to the system as they were warranted, and for attending to the concerns of hospitals serving rural Americans, particularly eliminating the differential between the standardized amounts for urban and rural hospitals by FY 1995. In addition, we welcome Mr. Stark's involvement in the House Rural Health Coalition. Moreover, we applaud the subcommittee's role in last year's budget reconciliation, which mandated development of an adjustment to standardized amounts to reflect variations in non-labor prices among hospitals.

Despite the accomplishments of PPS, many problems remain. PPS has come to represent a series of broken promises. The system pledged to provide payments that kept up with the rate of inflation plus 1 percent for technology. In reality, PPS payments per case have not kept up with costs. (See Chart 3) PPS established incentives for hospitals to keep costs down by allowing them to keep the difference between Medicare payments and their costs. However, as soon as a hospital is deemed to have made more than its costs, the entire Medicare program becomes a target for major cutbacks.

Technical problems with prospective payment persist. The PPS market basket, for example, does not take fully into account price increases, specifically hospital wage increases. The area wage index, which is constructed by Metropolitan Statistical Areas, does not recognize the changing shape of hospital labor markets and is increasingly unrepresentative of the wage differentials paid by hospitals across the nation. While we are optimistic that the newly created Medicare Geographic Classification Review Board will address some of these concerns, the larger issue remains to be resolved.

Perhaps the most significant failure of PPS is that it has not been allowed to work; it has become a victim of budget-driven policy. This has led to a lack of predictability within the program. Continual budget-driven policy changes have denied hospitals the opportunity to adequately plan for their financial future. Hospitals have already experienced the effects of nearly a decade of budget-driven policy decisions. The result has been a slow erosion of hospitals' financial stability and a redistribution of health care resources that sometimes has unintended consequences. AHA has addressed this subcommittee in the past concerning Medicare payment shortfalls. It is not news that hospitals have been losing money treating Medicare and Medicaid patients for some time. What is new is that these losses, the driving force behind hospitals' overall financial performance, are now reflected in the overall financial status of hospitals. For the first time in over a decade, hospitals' net patient margins are negative. In fiscal year 1990, hospitals' aggregate net patient margin was negative 0.2 percent. That is, for all patients treated, hospitals' expenses exceeded their patient revenue. As a result, hospitals have had to rely increasingly on other, shrinking sources of revenue such as state tax dollars, grants, contributions, and interest on cash balances to make up for the unpaid care of patients. Even with these additional sources of non-patient revenue, hospitals' financial positions are precarious. In fact, even after including revenue from all sources, patient and non-patient, at least 20 percent of all U.S. community hospitals report negative total margins.

Government payments for care provided to Medicare patients have gone from bad to worse. Hospitals have been losing money treating Medicare patients for the past three years. In FY 1989, hospitals lost 3 cents on every dollar of care delivered to Medicare patients. In FY 1990, they lost more than 6 cents on every dollar of care; and in 1991 they are expected to lose 9 cents on every dollar. AHA projects that in FY 1992 the aggregate Medicare PPS operating margin will be between negative 10 percent and negative 15 percent.

Exacerbating Medicare losses is the recent shift in admission trends at U.S. community hospitals. Admission of patients over the age of 65 had been declining through 1987. But in 1990, over 600,000 more elderly patients were admitted to hospitals than in 1987. At the same time, over 1 million fewer patients under the age of 65 were admitted to community hospitals. Thus, an increasing share of hospitals' patients are elderly Medicare patients. This demographic change is likely to continue as the population ages, aggravating an already difficult financial situation for hospitals. Under PPS, the payments hospitals receive for this growing Medicare population will be inadequate to cover costs, while at the same time there are fewer and fewer inpatients who actually pay for the full cost of the care they receive.

In addition to the problem of Medicare underfunding, Medicaid payments for patient care, although they vary from state to state, fall far short of costs, and the shortfall is increasing rapidly. Between 1980 and 1985, Medicaid paid about 90 percent of the cost of care for its recipients. During the second half of the decade, however, payments fell further and further behind each year. By 1989, Medicaid payments covered only 78 percent of costs. That is, in the aggregate, hospitals lost 22 cents on every dollar of care provided to Medicaid recipients. In fact, nine of 10 hospitals now are losing money serving Medicaid patients, and the extent of their losses is increasing each year.

As a result, Medicaid shortfalls are now the most important factor driving increasing hospital losses in caring for the poor. Preliminary AHA analyses show that in 1989, unreimbursed hospital care for the poor, which includes Medicaid and unsponsored care, totaled $13.2 billion. One-third of this ($4.3 billion) was due to Medicaid underpayment. While hospitals have traditionally focused on the growing cost of providing uncompensated care, the rising cost of Medicaid shortfalls is an increasingly significant source of financial difficulty for hospitals. (See Chart 4)

Taken in total, the magnitude of these hospital losses is staggering. Medicare and Medicaid shortfalls and hospitals' unsponsored care burden strongly reflect the inadequacies of government payments for hospital services and suggest that by underfunding health programs for the poor, aged, and disabled, the federal government, as well as state governments, are shifting responsibility for assuring access to high-quality care for these population groups onto the shoulders of other payers. To fully recover these costs from private purchasers, who on average generate less than 45 percent of gross patient revenue for hospitals, hospitals would have to increase charges by some 20 percent.

Although hospitals' financial status in 1991 appears shaky, their community commitment remains steadfast. In the midst of the turmoil that has affected the entire health care field, hospitals have gradually been expanding their role, becoming broad public service institutions that enhance the quality of people's lives in many areas. Virtually all community hospitals now have emergency departments staffed 24 hours a day or arrange with other facilities to provide emergency care for their communities. Three-fourths of all hospitals now offer outpatient services. Hospitals are providing more home health services, more outpatient rehabilitation services, and more alcohol and chemical dependency treatment.

In his budget message to the House Budget Committee, Secretary of Health and Human Services (HHS) Louis Sullivan stated, "Health promotion and disease prevention are critical to enhancing the health status of all Americans." Hospitals share the Secretary's belief. In fact, health promotion activities of hospitals have grown tremendously. Increasingly, hospitals are involved in planning and coordinating services to encourage people to adopt healthier behaviors, reduce health risks, and improve their understanding of medical procedures and therapeutic regimens. In 1985, half of all community hospitals offered health promotion services. By 1989, just four years later, more than 85 percent of hospitals offered these types of health promotion services. Hospitals nationwide are participating in Healthy People 2000, a national strategy by the U.S. Public Health Service to improve America's health by the turn of the century by encouraging health promotion activities.

We are concerned, however, that the persistent financial squeeze will impair hospitals' ability to adequately serve their communities. Inadequate federal and state government payments for hospital care are straining hospitals' ability to continue to provide needed quality acute care services, let alone expanded preventive and longer-term treatment services. Hospitals remain committed to providing access to care for all patients, but their continued ability to do so is in serious jeopardy.

The President's recent budget proposals fuel this fear. President Bush would again impose cuts in Medicare financing as a primary means of balancing the federal budget. This represents another in a series of broken promises to support quality health care and further widens the credibility gap between the administration, and hospitals and their patients. We would like to thank you, Mr. Stark, in your diligent pursuit of maintaining the five-year budget agreement and your recent efforts to seek the release of Medicare contractor funds. These efforts will help to assure continuity in the operations of our health care delivery system and will restore faith in our nation's commitment to quality care.

Among the President's proposals and those made by the Prospective Payment Assessment Commission (ProPAC), suggested reductions in the Medicare indirect medical education (IME) adjustment would have the greatest financial impact on hospitals. The President proposes a five-year reduction in the current adjustment factor from the current 7.7 percent to 4.4 percent in FY 1992 and eventually to 3.2 percent. ProPAC has recommended a less rapid five-year phase-down that would reduce the IME factor to 7.0 percent in FY 1992 and eventually to 4.2 percent. The President's proposal is expected to save over $1 billion in FY 1992 alone and nearly $9 billion over five years. Alternatively, ProPAC recommends that this change be implemented in a budget-neutral manner. That is, the money saved by reducing the IME adjustment would be redistributed through the Medicare standardized payment amounts to all hospitals.

We appreciate the subcommittee's continued support of this important adjustment and strongly urge you to reject any proposal designed to reduce it further. The financial viability of our nation's teaching hospitals is a major concern. Although teaching hospitals fared better than non-teaching hospitals during the early years of PPS, their financial picture is now equally as gloomy. In FY 1992, the estimated Medicare margin for teaching hospitals is negative 7 percent to negative 12 percent. ProPAC's proposal to cut the IME adjustment would have the effect of further reducing teaching hospitals' Medicare margins to between negative 8 percent and negative 13 percent. The President's more draconian approach would reduce margins to between negative 13 percent and negative 18 percent.

This adjustment clearly is crucial to the survival of teaching hospitals, and these hospitals are essential to meeting future medical manpower needs as well as to providing needed access for Medicare and Medicaid patients and the medically indigent. Despite this adjustment and the added support of disproportionate-share payments by this subcommittee, teaching hospitals remain financially stressed. Hospitals are committed to care for the poor, the uninsured, and the underinsured, but we need to look for additional mechanisms to ensure adequate payment for these special population groups.

The Bush budget would also make additional cuts in outpatient payments to hospitals, saving $50 million by basing payments for ambulatory surgery, radiology, and diagnostic procedures on a prospective rate. In light of the congressional mandate to ProPAC and HHS to develop and analyze a plan by March of 1992 to pay for all outpatient services on a prospective basis, this savings proposal is yet another example of budget-driven health policy with no rational basis. These cuts will disproportionately and dramatically affect rural hospitals, which have responded to PPS incentives to deliver care in the most efficient setting--often the outpatient department. Moreover, we would like to take this opportunity to remind you of the AHA proposal for prospective outpatient payment, and urge that you consider it with other proposals on the table. AHA proposes that in the long term Medicare should adopt a prospectively determined procedure-based fee schedule for payment of hospital and other outpatient services, with interim payments based on per-procedure average operating cost limits.

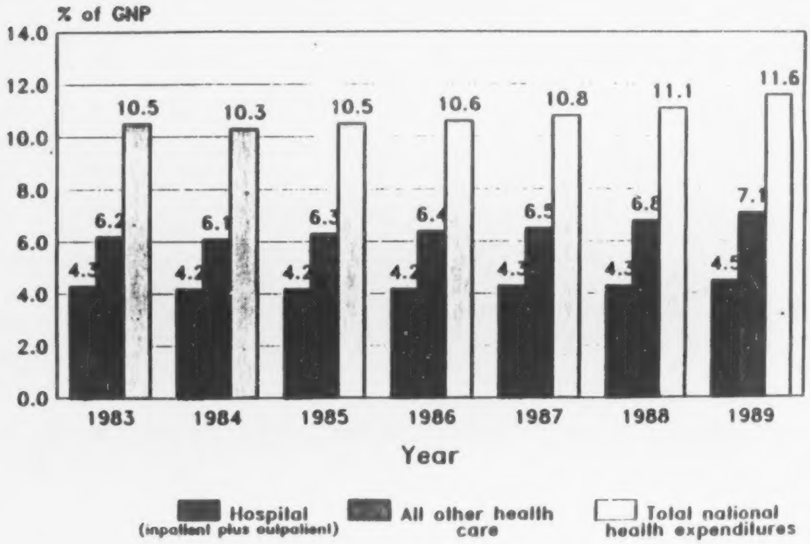
Finally, Mr. Chairman, we would like to comment on another, somewhat hidden threat to hospitals, the "pay-as-you-go" process reform provisions of the Budget Enforcement Act. Our concern is twofold. First, the President's proposals to reduce Medicare spending for hospitals may be viewed by some as an opportunity to fund expansions of other mandatory spending programs without passing the requisite financing mechanism. This clearly violates the spirit of the "pay-as-you-go" provisions. Second, hospitals remain vulnerable under the new system and must rely on the good-faith efforts of others to comply with the new provisions of the Budget Enforcement Act. If others neglect their responsibility to find complementary funding means for program expansions, hospitals may still experience payment reductions if a sequester is triggered. AHA urges the committee to be vigilant in monitoring the new pay-as-you-go process. Particularly in the case of Medicare, dedicated trust fund dollars should not be used to fund other programs or to fund deficit reduction. To prevent the inappropriate draining of Medicare reserves that could result, the trust funds should be moved off-budget and removed from deficit calculations for purposes of meeting the Gramm-Rudman-Hollings deficit targets which become operative again in FY 1994.

CONCLUSION

We as a nation must assure that our growing health care needs will be met in the most sensible and efficient manner. We need to focus on the future, but the time to do so is now. AHA will continue to work with hospitals and other stakeholders in the health care field to develop viable options for reforming our health care system, and we look forward to working further with your committee and others in Congress to achieve this common goal.

CHART 1

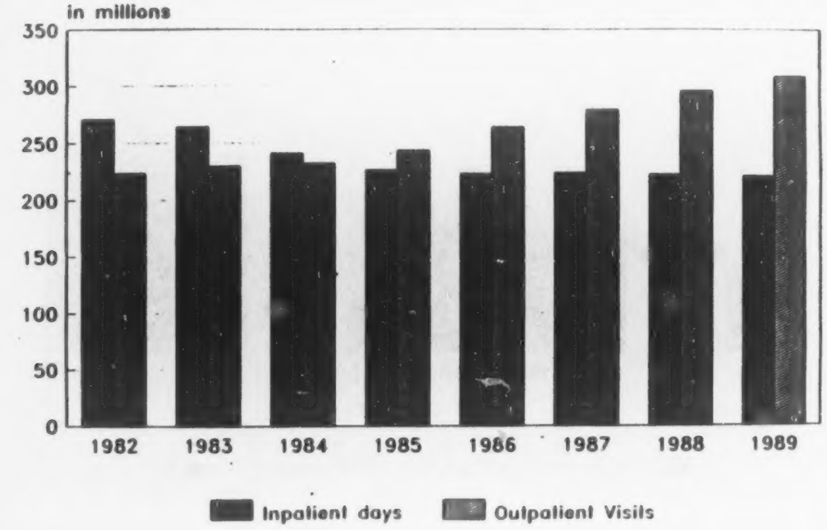
NATIONAL HEALTH CARE EXPENDITURES AS A PERCENT OF GNP



Source: HCFA Office of the Actuary

CHART 2

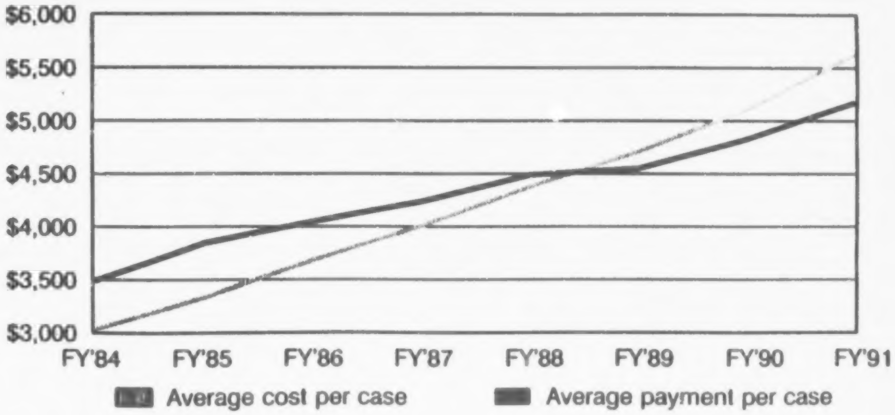
LONG TERM TRENDS IN HOSPITAL UTILIZATION



Source: AHA, National Hospital Panel Survey

CHART 3

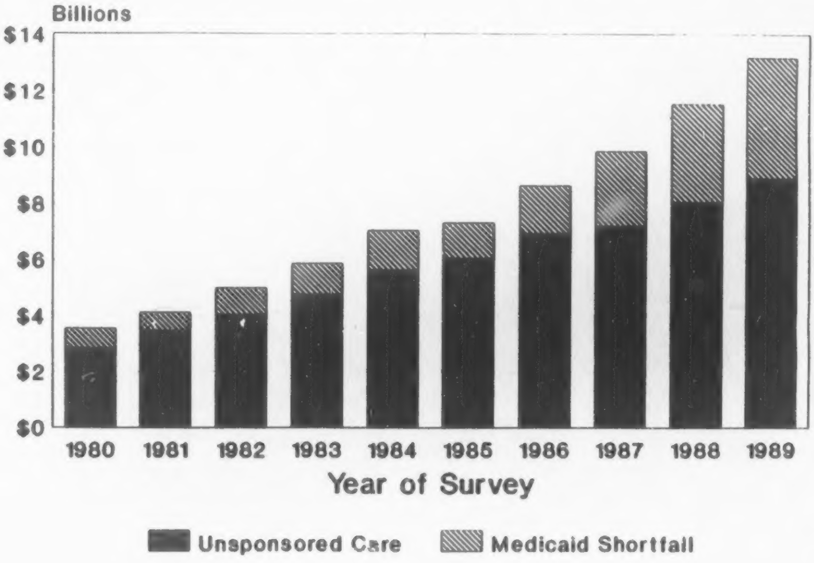
PPS PAYMENTS AREN'T KEEPING UP WITH HOSPITAL COSTS



Source: FY '84-FY '88 - HCFA Medicare Cost Report Tapes
FY '89-FY '91 - Preliminary AHA Projections

CHART 4

MEDICAID SHORTFALL PLUS UNSPONSORED CARE



Source: American Hospital Association

Chairman **Stark**. Larry.

STATEMENT OF LARRY S. GAGE, PRESIDENT, NATIONAL ASSOCIATION OF PUBLIC HOSPITALS

Mr. **Gage**. Thank you very much, Mr. Chairman, members of the subcommittee. I am Larry Gage, president of the National Association of Public Hospitals. NAPH's membership includes over 100 metropolitan area safety net hospitals with combined revenues of over $10 billion. Nearly, 20 percent of that comes in the form of direct subsidies for uninsured patients. Earlier this month, NAPH released a major study of our member hospitals, a whitepaper entitled "America's Health Safety Net," and we have provided copies of that white paper to your staff in connection with this hearing.

In this, as in earlier reports, NAPH warns of an increasing reliance by uninsured patients on this small group of safety net hospitals, and a corresponding weakening of their programs, services and financial situation. Due to your outstanding leadership, Mr. Chairman, and that of the other members of this subcommittee, we are extremely gratified that a number of reforms called for by NAPH in earlier reports have now been adopted. But despite these gains, the needs of these hospitals and the patients they serve remain great. There has been a significantly increased demand for services in recent years by new populations of safety net patients, including persons with AIDS, the homeless, drug abusers, trauma victims, and high risk pregnant women. And at the same time, growing State and local budget crises, as you heard earlier from Dr. Altman, have left many governments unable to meet the full need for subsidies to pay for this increased demand.

I think just three facts taken from our report will illustrate the current situation. The first fact is that 30 percent of the inpatient days and 52 percent of all of the outpatient visits to NAPH member hospitals are uncompensated. The second is that bad debt and charity care as a percent of charges increased from 22 percent for these hospitals in 1982 to 42 percent in 1988, and the third is that NAPH hospitals had an overall average net operating deficit of more than $9 million in 1988, even after direct local subsidies were taken into account. I might note that this is not a deficit based on charges. It is based on a comparison of actual operating costs with actual revenues received.

With respect to the President's Medicare budget, I think it is important to note that Medicare, while a relatively smaller source of payment for many of these hospitals than the rest of the industry, is still the largest and most important nonindigent payer in most of our hospitals, and is an essential part of their patient care revenues. For this reason, NAPH strongly opposes the administration's Medicare budget proposal, particularly for indirect and direct medical education. We agree with the ProPAC analysis about these adjustments serving as a proxy for overall fiscal soundness, and we clearly need to pay attention to the overall margins of institutions in inner-cities.

With respect to other recommendations, we strongly believe that the enactment of a national health plan must remain an important goal, and we are very pleased to see that you have introduced H.R.

650 and are planning to take an active role in this debate. In my prepared testimony, we offer several criteria for what we consider to be important components of any national health plan. While we continue to debate how to pay for national health insurance, we also believe that two other major new initiatives are needed in the short run to protect the programs and services of these hospitals. Direct institutional support must be provided for safety net hospitals serving large numbers of uninsured, low income patients, in the form of a national indigent care or uncompensated care trust fund with dedicated sources of revenues. Legislation originally developed by you, Mr. Chairman, and introduced in the last Congress as H.R. 754 could serve as a model for this legislation.

I might say that we do agree with others in the industry that you can only carry Medicare so far in terms of paying for the costs of uncompensated care, and we must develop some non-Medicare interim measures as well.

Finally, a new capital financing initiative is also needed to rebuild and equip our health safety net infrastructure. I have described several capital financing options and some of the needs in this area in greater detail in my testimony.

In terms of cost containment, I might note that some of the most perverse efficiencies are found in the public hospital sector. I point to the charity hospital system in Louisiana, which is 40 percent more efficient in a cost sense than other hospitals in the State of Louisiana. But that is because of aging physical plants, deferred maintenance, the inability to staff, and tremendous pent up capital needs. The charity system has already closed inpatient care at three of their facilities and in some cases has closed down services that are badly needed

So we look forward to working with the subcommittee to develop some appropriate options in each of these areas, and I would be happy to answer any questions.

Chairman **Stark**. Thank you.

[The prepared statement follows:]

Statement of Larry S. Gage
President

National Association of Public Hospitals

before the

Subcommittee on Health
Committee on Ways & Means
U.S. House of Representatives

February 27, 1991

Mr. Chairman, members of the Subcommittee, I am Larry Gage, President of the National Association of Public Hospitals (NAPH). NAPH has for the last decade represented a significant proportion of America's metropolitan area safety net hospitals. Today, NAPH members include 100 hospitals. This may seem like a small number, in a country that boasts nearly 6000 acute care hospitals. But these 100 institutions (taken together) comprise America's most important health and hospital system. With combined revenues of over $10 billion, these major, tertiary teaching hospitals truly serve as "national health insurance" by default in our nation's urban areas.

I am pleased to have this opportunity to report to you today on the situation of these essential providers, and to comment on the President's budget, the Medicare program, and the urgent need for additional reforms. Earlier this month, NAPH released a major study of our member hospitals, a White Paper entitled "America's Health Safety Net". This study includes a significant amount of new information, and also updates information we have gathered and reported to you (and the nation) twice before -- in 1982 and 1987.

In each of those previous reports, NAPH warned of an increasing reliance by uninsured patients on this small group of safety net hospitals -- and a corresponding weakening of their programs, services and financial situation. In each of those reports, NAPH also called for a number of health system reforms aimed at improving the situation of these institutions and the patients they serve.

Due to your outstanding leadership, Mr. Chairman, and that of the other members of this Committee, we are extremely gratified that a number of the reforms called for by NAPH in previous reports have now been adopted. We are also grateful, Mr. Chairman, that you have helped us convince many other federal, state and local policymakers that this safety net is a fragile one, which must be supported and preserved.

The term "disproportionate share hospital" (DSH) is perhaps an inartful one, but it has now taken on real meaning in the Medicare, Medicaid and other health programs, and billions of dollars have now been paid to DSH hospitals through such reimbursement adjustments. Capital access programs like the FHA Section 242 Hospital Mortgage Insurance have also been opened up to public hospitals in the last several years. (The FHA program has now been used successfully by a major urban public hospital, Boston City Hospital). Funds for hospital trauma care, and for the medical care of special populations such as legalized immigrants and AIDS patients, have now been authorized by Congress, although appropriations remain a constant battle with these new programs.

Despite these gains, the needs of America's safety net hospitals, and the patients they serve, remain great. There has been a significantly increased demand for services in recent years by many new populations of safety net patients, including persons with AIDS, the homeless, drug abusers, trauma victims, and high-risk pregnant women. This increased demand has, in turn, also increased the need by safety net hospitals for direct subsidies by local (and in some cases state) governments. However, in many cases, state and local budget crises and taxpayer revolts have left such governments unable or unwilling to meet the full need for direct subsidies.

These factors have further eroded the viability of many safety net hospitals. This in turn has affected their ability to develop new services, expand primary and preventive care, or get access to capital funding for maintenance, new technology and renovations.

For these reasons, it is imperative that policy-makers continue to respond to those needs at all levels of government over the next several years. NAPH member hospitals strongly believe that both comprehensive and incremental reforms and initiatives will need to be considered, discussed, and enacted during that period.

In the remainder of my testimony this morning, I will try to accomplish two things: first, to describe the current situation of America's urban safety net hospitals in greater detail, using data from our recently issued White Paper; and second, providing you with several recommendations for future reform, and with NAPH's comments and observations on the Medicare program and the President's budget proposals.

I. OVERVIEW OF THE SITUATION OF SAFETY NET HOSPITALS

THE VOLUME OF SERVICES PROVIDED BY SAFETY NET HOSPITALS CONTINUES TO INCREASE, AND OVERCROWDING IS BECOMING A SERIOUS PROBLEM IN SOME INSTITUTIONS.

The average NAPH member hospital had 526 beds and admitted almost 20,000 inpatients in 1988, representing almost 160,000 inpatient days. NAPH members experienced an average of over 71,000 emergency department and 190,000 outpatient department visits in 1988. NAPH member hospitals also delivered an average of more than 4,000 babies. Some NAPH member hospitals experience as many as 400,000 clinic visits and 15,000 births annually.

53% of all admissions to NAPH safety net hospitals were through the emergency department in 1988 (more than 70% for some hospitals), and many emergency and clinic patients are waiting longer to see doctors or be admitted. 58% of NAPH hospitals reported periodic waits by emergency department patients of 12 hours or more for admission, and half of all hospitals surveyed reported that some patients were forced to wait more than 24 hours.

A SUBSTANTIAL PROPORTION OF THE PATIENTS OF SAFETY NET HOSPITALS ARE UNINSURED, AND THEIR NUMBER IS GROWING.

Over 30% of inpatient days and 52% of outpatient visits to NAPH member hospitals were by uninsured patients in 1988. This represents over 2.9 million inpatient days and 6.9 million uninsured outpatient visits, including emergency department visits. 36% of inpatient days and 25% of outpatient visits were by Medicaid patients; 19% of days and 13% of visits by Medicare patients, and only 15% of days and 10% of visits to safety net hospitals were by patients with private insurance. The proportions of privately insured, Medicare and Medicaid patients have decreased in the last several years, while the proportion of uninsured has increased.

SAFETY NET HOSPITALS ARE LOSING MONEY ON EVERY CATEGORY OF PATIENTS THEY SERVE; JUST 57 NAPH MEMBER HOSPITALS LOST MORE THAN $530 MILLION THROUGH OPERATIONS IN 1988.

Fifty-seven NAPH member hospitals recorded gross revenues (charges) of $10.3 billion in 1988. However, 35% of these gross charges were attributable to uninsured ("self pay") patients, and net operating revenues (including direct local subsidies in addition to patient care revenues) totalled only $8.1 billion.

Gross charges for Medicaid patients in safety net hospitals averaged nearly $55 million per hospital in 1988, while collections averaged only $39.8 million (or 72%). Gross charges for Medicare patients averaged $33.6 million in 1988, while Medicare collections averaged only $24.7 million (73%). Average NAPH member hospital gross charges were highest ($63.2 million) for "self pay" patients -- a population from whom patient care collections were also lowest ($15.5 million, or just 24.6%).

As a result of this bleak collections picture, NAPH member hospitals averaged operating deficits of over 30% in 1988 before direct subsidies are taken into account; even with direct subsidies, NAPH members averaged deficits of $9.4 million, or approximately 6%. When net operating revenues (including subsidies) are compared with operating costs, 57 NAPH member hospitals experienced a total shortfall of $534 million in 1988. This operating shortfall was made up in many instances by deferring maintenance or needed capital purchases, through layoffs (or the inability to fill staffing vacancies), and through other extraordinary means.

LOCAL GOVERNMENT PLAYS A SIGNIFICANT ROLE IN FUNDING THE HEALTH SAFETY NET, AND THE PROPORTION OF CARE FUNDED BY LOCAL GOVERNMENT HAS RISEN.

As the data summarized above underscore, many city and county governments (and a few states) play a significant role in directly subsidizing the uncompensated care provided by America's safety net hospitals. Total direct subsidies to 57 NAPH member hospitals amounted to $1.665 billion in 1988. This exceeded total Medicare collections ($1.406 billion) and total private insurance collections ($1.389 billion) by these hospitals.

Nationally, it has been estimated that cities, counties and other local governmental entities contribute upwards of $12 billion annually to subsidize direct patient care for the uninsured poor. One recent study found that cities or counties in 54 metropolitan areas contributed an average of over $30 million each to indigent hospital care.

During the 1990 debate over Medicare and Medicaid spending reductions, it was implied by some private sector hospital lobbyists that increased DSH payments under those programs have resulted in reduced local commitments. Yet nothing could be further from the truth. In many urban areas, direct city, county (and in some cases, state) subsidies have in fact **increased along with Medicare and Medicaid payments** in recent years. Although safety net hospitals received an increased Medicare DSH adjustment in 1989, for example, Los Angeles County actually found new revenue sources to increase the direct subsidy to the county hospital system by $60 million. In Louisiana, direct state subsidies to Charity Hospital of New Orleans increased by $48 million. And direct subsidies also increased last year in New York City, Kansas City, Atlanta, Washington D.C. and elsewhere.

MANY SAFETY NET HOSPITALS RECEIVE LITTLE OR NO DIRECT SUBSIDIES.

Of more than 1500 hospitals that receive a Medicare DSH adjustment, at least 250 provide **significantly** disproportionate services to low income patients. Many of those 250 hospitals -- perhaps even a majority -- are public or nonprofit providers that maintain their "open door" safety net mission with little or no benefit of subsidies. This is due in some cases to their private status, but even for many public hospitals, the local tax base is limited by the size of the population, the state of the local economy, or state constitutional taxing limits. If these hospitals receive subsidies at all, their payments have often been capped for years at relatively low levels. Examples of such hospitals, which must finance their operations primarily from Medicare, Medicaid and other third party revenues, include the University of New Mexico/Bernalillo County Medical Center, Memorial Medical Center of Savannah, Pontiac General Hospital, Seattle's University Hospital/Harborview Medical Center, Minneapolis' Hennepin County Medical Center, Chattanooga's Erlanger Medical Center, Amarillo's Northwest Texas Hospital, the University of Nebraska Hospital, St. Luke's Roosevelt Medical Center, the University of Chicago Hospitals -- the list is a long and distinguished one.

THE NEEDS OF SPECIAL POPULATIONS HAVE CONTINUED TO DOMINATE THE MISSION AND PROGRAMS OF SAFETY NET HOSPITALS, AND TO CAUSE FINANCIAL HARDSHIP.

Special populations include persons with AIDS, drug abusers, trauma victims, the deinstitutionalized mentally ill, the homeless, and other low income patients in need of long term or home care. For example, in a survey of 15 NAPH member hospitals, it was determined that 29% of all emergency department visits were drug-related in 1988. In the sample selected, during a one month period, 4,583 individuals had drug abuse as their primary diagnosis, while in 14,066 cases, drugs were a complicating factor in these safety net institutions. One hospital (Harbor/UCLA Medical Center) reported that 67% of all emergency department visits on one evening were drug or alcohol related.

Another survey of 30 NAPH member hospitals reported an average of 104 cocaine-addicted newborns per hospital in 1988, and 61 for the first half of 1989 -- a 17% increase. D.C. General Hospital reported that 20% of all newborns during the period surveyed in 1988 and 1989 tested positive for illicit drugs, while Los Angeles County's King-Drew Medical Center reported 600 cocaine-exposed infants in 1988 and 325 in the first half of 1989.

In the case of the homeless, one NAPH member (Bellevue Hospital Center) estimated that 20% of all inpatients were homeless at discharge, and that such patients required stays that were twice as long as other patients. Among 19 NAPH members surveyed, 6% of all inpatient days were taken up by so-called "administrative" patients -- patients able to be discharged but who had no place to go. This represents an average of 11,284 days per hospital.

THE ROLE OF NAPH MEMBER HOSPITALS IN THE AIDS EPIDEMIC HAS CONTINUED TO ESCALATE IN SCOPE AND IMPORTANCE.

The number of AIDS inpatients treated in NAPH member hospitals has tripled since 1985, from 2,977 patients and 4,267 admissions, to 9,495 inpatients and 15,626 admissions in 1988. Inpatient days during that period increased from 91,094 to 276,220. NAPH member hospitals continue to lose money treating AIDS patients, losing an average of $4,903 for each admission. Losses for the 15,626 admissions to NAPH hospitals totalled $76.6 million in 1988. The financial situation is particularly troublesome in those parts of the country where Medicaid coverage is inadequate. This is graphically illustrated by examining the extent of Medicaid eligibility by region: 70% of AIDS patients were covered by Medicaid in the Northeast and 66% in the West, as compared with 44% in the Midwest and just 25% in the South. Conversely, only 10% of all AIDS patients in the Northeast were "self pay" patients, as compared with 23% in the West, 25% in the Midwest, and a whopping 61% in the South.

Average length of stay for AIDS patients has been slowly decreasing in NAPH member hospitals, as treatment has become more widely available outside of hospitals. ALOS decreased from 21.3 to 17.7 days between 1985 and 1988 nationally. However, the availability of alternative treatment modalities was much more highly developed in the West, where ALOS was just 10.9 days, than in the Northeast, with an ALOS of 24.2 days. (This difference is also partly accounted for by the much greater proportion of low income, minority drug abusers among Northeast AIDS patients.)

DESPITE THESE MANY PROBLEM AREAS, SAFETY NET HOSPITALS CONTINUE TO OFFER THE VERY HIGHEST QUALITY OF HEALTH CARE, WITH STRONG PROGRAMS OF MEDICAL EDUCATION AND THE CONTINUED GROWTH AND DEVELOPMENT OF MANY AREAS OF EXCELLENCE.

Notwithstanding the threats to survival spelled out in NAPH's new White Paper, many safety net hospitals continue to offer the very highest quality of medical services available anywhere in the hospital industry. These include high-cost tertiary services, such as trauma care, burn units, and neonatal intensive care, and high quality primary care. For example, over three-fourths of NAPH member hospitals have trauma centers, as compared with just 13% of all hospitals nationally, and 78% of those are Level I centers.

In part, this concentration of specialty services is due to the important medical education role NAPH members continue to play, which guarantees a strongly committed and competent medical staff at all levels. NAPH members on average trained 191 residents in 1988, or over 7,500 in all (this represents 12% of all residents trained in America).

Successes have been achieved by many safety net hospitals in developing and marketing specialty services as "Centers of Excellence" to private patients in addition to the uninsured or others with special needs. These successes can be traced in part to the extraordinary medical and administrative leadership to be found in these hospitals. As the innovative programs described in our White Paper clearly illustrate, physicians, nursing staff, and administrators of NAPH member hospitals can be as creative as they are dedicated and compassionate. Leadership has also been evident in the area of Medicaid managed care programs. Successful public sector managed care plans have been developed in Contra Costa County and San Mateo County, California; Minneapolis and St. Paul, Minnesota; Phoenix; Miami; and elsewhere.

II. SUMMARY OF COMMENTS & RECOMMENDED REFORMS

The information and analysis presented in this testimony illustrate with precision the immense problems faced by America's safety net hospitals. And while there have clearly been gains made over the last several years, there also remain significant opportunities for future reforms and initiatives. NAPH's proposals as to the scope and content of those reforms and initiatives, as well as our comments on the President's budget and the Medicare program, are outlined and briefly described in the remainder of my testimony.

UNIVERSAL ACCESS TO HEALTH COVERAGE MUST BE GUARANTEED TO ALL AMERICANS BY THE END OF THE COMING DECADE.

Universal health coverage must remain the single most important legislative and policy goal of our nation's health system. To be truly effective, NAPH members believe that a nationwide program is an essential component of genuine health coverage reform. Unfortunately, thus far the federal government has not taken the lead in achieving this goal, continuing instead to abdicate this leadership role to the states, and to individual members of Congress.

In particular, NAPH commends you, Mr. Chairman, for already introducing important legislation in this area in the current Congress, and we look forward to working with you on H.R. 650. We are concerned, however, that the prospects for immediate enactment of major reforms at the federal level are not encouraging, in light of such factors as the Gulf war, the recession, and the size (and growth) of the federal deficit.

There has also been a high level of activity and discussion in a small handful of states -- such as the trailblazing actions of Hawaii and Massachusetts. But Hawaii's requirement for universal coverage benefits greatly from that state' geographic and economic isolation, as well as from a hard-to-replicate ERISA exemption that permits the state to regulate self-insured employers. In addition, while ambitious in concept, the Massachusetts experiment now appears very close to being dismantled.

Several states, like the state of Washington, have recently enacted more limited risk pools or other demonstration programs which are intended to apply initially only to certain parts of the state, or to subgroups within the population. Other states, like California, New York, Michigan, Illinois and Oregon, have ambitious proposals in the hopper, but with no clear indication of a timetable for enactment. All in all, while there is considerable discussion of states becoming the laboratory for a universal health coverage plan, their performance to date has been disappointing. Moreover, the combination of sobering deficits and newly elected governors in many states will probably keep many state proposals on a slow track.

Given this track record, it is perhaps understandable that NAPH member hospitals as a group are relatively pessimistic about the short run prospects for achieving universal access and coverage at the national level, or in many states. NAPH members remain convinced that incremental reforms at best will be achievable for most of the 1990s, and that considerable attention should be concentrated in that direction. However, to assist you, Mr. Chairman, as well as other health industry leaders and legislators who are still willing to push for such system-wide reform, NAPH is pleased to set forth some essential criteria for any program of universal health access and coverage for all Americans. The following principals, at a minimum, have been endorsed by NAPH member hospitals as essential to any national health plan:

- While incremental improvements are acceptable in their own right, the goal of any national health plan must be nothing less than universal access or coverage for all.

- However, not every individual needs to receive **insurance** coverage to be guaranteed true access under a universal health plan; it must be recognized that there will always be individuals who fall through the cracks, and that it is acceptable to provide access for such persons through the preservation of a strong and well-financed **institutional safety net.**

- A national health plan must require the federalization of the Medicaid program, and quite possibly its elimination and merger with Medicare.

- A core national minimum benefit package must be developed that is not too rich as to be unaffordable, yet covers essential preventive, primary care and hospital services, and guards against the prospects of catastrophic illness.

- The present system of private insurance can continue under a national health plan, but insurance reform is an essential part of any national health package; the federal government should preempt state regulation to the extent necessary to set national standards for health insurance plans, which include mandating minimum benefit packages on all employers above a reasonable size, reinstatement of community rating, and curbing current trends toward exclusion of preexisting conditions (or setting post-illness limits on specific diseases such as AIDS).

- States must be permitted wider latitude to experiment with new plans, including the ability to waive ERISA constraints on the regulation of self-insured businesses.

- Any national plan must include a heavy emphasis on preventive and primary care and must provide adequate support for initiatives to encourage changes in lifestyles.

THE MEDICARE DISPROPORTIONATE SHARE HOSPITAL AND MEDICAL EDUCATION ADJUSTMENTS MUST BE PRESERVED AND INCREASED.

Medicare, as the data in this testimony shows, is a relatively smaller proportion of the patient load in safety net hospitals than in the rest of the industry (only 18%, as compared to 34% on average for the industry as a whole). However, Medicare is usually the single most important **non-indigent** payor in many safety net hospitals, and as such, constitutes an essential part of patient care revenues.

Great strides have been made in mandating Medicare payment adjustment increases for "disproportionate share hospitals." This program has grown from paying just $200 million in its first year to well over $1 billion in 1990. In the last two years, Congress has also refrained from making any further reductions in the indirect teaching adjustment. This has resulted for the first time in actual real dollar gains in Medicare reimbursement for safety net hospitals, although these gains have not succeeded in erasing the significant operating deficits of such hospitals (such deficits currently average over $9 million, or -6%).

Ironically, these real gains have also resulted in the Medicare disproportionate share adjustment coming under fire for the first time in the legislative process. In particular, it was argued in the 1990 reconciliation act debate that "it is not the role of the Medicare program to finance care for the uninsured." However, this debate actually proved to be positive for safety net hospitals, in that it gave legislators an opportunity to state clearly that Medicare, along with all other payors, **does have a continued role in sharing the burden of financing care for low income patients, and the specialized services offered by safety net hospitals,** -- at least until such time as our nation achieves universal health coverage!

For these reasons, NAPH strongly opposes the Administration's Medicare budget proposal, which would reduce Medicare spending by $2.8 billion more in FY 1992 than was agreed to in OBRA 1991. A significant proportion of that reduction would come from the indirect teaching adjustment, which would be decreased from 7.7% to 4.4% in FY 1992, and to 3.2% by FY 1996. In addition to violating the five year budget agreement reached last year, this reduction simply fails to take into account the full range of additional needs and services provided by many major, urban teaching hospitals.

The Administration also proposed reducing direct medical education payments in FY 1992 by $140 million, through the application of new payment methodology for house staff. This methodology would pay teaching hospitals on the basis of a national average house staff salary, and would significantly differentiate between payments for primary care and specialty residencies. While NAPH members appreciate the need to emphasize (and attract candidates to) residencies in primary care specialties, we are extremely concerned that a blanket differential in payments for all specialty residencies would fail to address the variety of factors that affect many specialties and training programs. Moreover, using national average salaries would very likely discriminate against hospitals in geographic areas with significantly higher living costs, and against institutions in major urban areas generally.

Finally, with respect to Medicare GME payments, 1991 saw a significant effort to recoup past direct medical education payments **by changing reimbursement rules and then attempting to apply those changes retroactively.** HCFA's major efforts last year to audit GME payments on the basis of regulations adopted in 1989 are based on Federal legislation adopted by the Congress in 1985. However, we are concerned that the HCFA regulations and audits differ in several major ways from the original statutory intent, and further, with the retroactive application of 1989 regulations to cost reports dating all the way back to 1984. We are pleased and grateful that the Congress, with the leadership of your Committee, intervened in OBRA 1990 to slow down HCFA's recoupment effort. We are concerned that considerable additional vigilance in this area will be called for on your part this year, and we hope to work with you closely on this important matter.

DIRECT INSTITUTIONAL SUPPORT FOR SAFETY NET HOSPITALS MUST BECOME AN IMMEDIATE FEDERAL PRIORITY.

While Medicare clearly has a role to play in sharing the financial burden of safety net hospitals, it is also true that additional measures are needed. In particular, as the debate over universal health coverage drags on, it is imperative that the Congress enact some form of **nationwide institutional support for safety net hospitals.**

Ideally, this should take the form of a national uncompensated care trust fund, with dedicated sources of revenue. Legislation originally developed by you, Mr. Chairman, and introduced in the last Congress as H.R. 754, could serve as a model. That legislation would create a trust fund with the proceeds of a small tax on health insurance premiums; such a tax could generate potentially $600 million to $1 billion for distribution to high volume providers of uncompensated care. Other potential funding sources that have been mentioned include taxes on alcohol, tobacco and firearms, as well as a national excise tax on hospital utilization.

A NEW NATIONAL CAPITAL FINANCING INITIATIVE IS NEEDED TO REBUILD AND EQUIP AMERICA'S INSTITUTIONAL HEALTH SAFETY.

Safety net hospitals also face a substantial need for adequate capital to rebuild and equip our nation's health infrastructure. A new NAPH study, which I have submitted to your staff, estimates that there are at least $15 billion in unmet capital needs among these essential urban providers. Yet these hospitals also face significant barriers in obtaining access to capital, as well as in their ability to repay incurred debts entirely from patient care revenues. In order to meet these needs, a new Federal capital financing initiative is clearly needed. Options for such an initiative might include direct federal grants and loans, debt service subsidies, and credit enhancements such as mortgage or bond insurance. While we do not envision such a program directly involving Medicare capital payments, it may be possible to draw upon the financial strength of the Medicare trust fund to enhance the credit of safety net hospitals. Eligibility for such a new program should clearly involve a high standard of need in urban and rural areas, and hospitals accepting assistance should probably also be willing to meet long-term indigent care and community service requirements, and perhaps other reporting and utilization requirements. We look forward to working with this Subcommittee to develop some appropriate options in this area.

UNLESS AND UNTIL UNIVERSAL COVERAGE BECOMES A REALITY, CONTINUED EFFORTS MUST BE MADE TO REFORM THE MEDICAID PROGRAM.

We recognize that Medicaid is not within the jurisdiction of this Committee, but for the sake of completeness, we would like to take this opportunity to point out that continued reform is essential in this program as well. Recent improvements in the Medicaid program have expanded eligibility for pregnant women and children, permitted states to continue using a variety of mechanisms for providing extra payments to disproportionate share hospitals, and permitted public and private hospitals to participate in the financing of Medicaid expansions through voluntary donations and the transfer of funds by local governments to states. In addition, states like Florida, New York and New Jersey have used provider taxes or all-payor systems to redistribute revenues and enhance Medicaid payments. **It is imperative that states be permitted to continue to make use of these alternative sources of revenues, at a time when many are suffering severe budget crises.**

However, even with the availability of the augmented payment sources described above, only about half of all states pay significant differentials to "disproportionate" safety net hospitals. And a number of states continue to subject hospitals to inadequate base payment rates as well, as is evidenced by the proliferation of lawsuits brought by hospitals against state Medicaid agencies around the country. **Both reasonable and adequate Medicaid payment rates, and meaningful disproportionate share hospital payments, must be enforced upon all states.**

THE INDIGENT CARE ROLE OF THE PRIVATE HOSPITAL SECTOR, AND OTHER HEALTH CARE PROVIDERS, MUST BE CLARIFIED AND STRENGTHENED.

The need for health services by uninsured patients continues to escalate dramatically -- and the predicted recession can only increase this demand. At the same time, due to competitive and reimbursement pressures, many private hospitals (and other providers) have aggressively sought ways to reduce services to uninsured safety net patients. Quite simply, the willingness and ability of private providers to shift the costs of uncompensated care to privately insured individuals have been significantly eroded in recent years.

Emergency department closures -- trauma center decertifications -- the abandonment of high risk tertiary services -- the curtailment of outpatient services -- these private sector actions have increased pressure tremendously on safety net providers.

What is the appropriate and equitable role of the private sector? Your Subcommittee has played a leadership role in this area as well, Mr. Chairman, and we urge your continued attention to this important issue. In addition, other policymakers at the federal, state, and local levels have been increasingly asking this question.

NAPH believes that all of these trends are necessary and should be encouraged by safety net hospitals, if only to counterbalance the economic and competitive pressures that are driving some private providers to reconsider the strength of their commitment to community service. But safety net patients should not have to rely on the grudging enforcement of legal rights against private hospitals. We believe that mechanisms can and must be established to encourage a voluntary sharing of the burden by all health care providers, public and private, and that the business community must also be involved in this effort.

In conclusion, NAPH strongly believes that there are adequate revenues overall in our nation's health system to permit private providers to pitch in and assume their fair share of the indigent care burden. This, in turn, will alleviate the pressures and enhance the survivability of the safety net.

A common misconception with respect to our nation's health system is that we lack the resources to both expand access for the uninsured, on the one hand, and preserve the quality of care most Americans have come to expect, on the other. Nothing could be further from the truth. Overall health spending exceeded $600 billion in 1990 -- up from $230 billion in 1980 -- and annual per capita spending approached $2,600 -- or over $10,000 for a family of four! Even the most conservative observers estimate that those figures will double by the year 2000. The American Academy of Pediatrics estimates that providing a basic benefit package for the nation's 10 to 12 million uninsured children would cost just $458 per year per child.

Most assuredly, we do not lack for resources to increase health coverage and implement other needed health system reforms. All we need is a commitment to devote a small proportion of our nation's projected **future increased health spending** to filling coverage gaps and meeting unmet needs. This is something we should easily be able to accomplish if we can simply bring some greater governmental and private sector discipline to the way our resources are currently spent. On behalf of the governmental and private entities that comprise NAPH, we are pleased to offer you our partnership and support in this effort.

I would be happy to answer any questions you may have at this time.

Chairman STARK. Mr. Van Hook.

STATEMENT OF ROBERT T. VAN HOOK, EXECUTIVE DIRECTOR, NATIONAL RURAL HEALTH ASSOCIATION

Mr. VAN HOOK. Mr. Chairman, members of the subcommittee, my name is Bob Van Hook. I am executive director of the National Rural Health Association based in Kansas City. It is, again, my pleasure to come before you to report on the state of rural hospitals, at least from our perspective. That National Rural Health Association and the Nation's rural hospitals would really like to thank the committee for its support over the last several years. We have seen a new era of fairness, and it has really been welcome. And Mr. Stark, we also want to welcome you to the coalition. We think that is a nice thing. We almost brought you a baseball cap, but we thought better of it.

Thanks in part to your efforts and to the efforts of other people in this body, the rural hospitals in this country are doing a little bit better, but there are still a few old problems, as well as new challenges. Many of the actions in this subcommittee have contributed to the increased ability of rural hospitals to develop creative solutions to the challenges they face in their communities. Some of these things that have happened are not really relevant to Medicare, but there are some other important issues that have come up over the last several years.

Let me talk about just a few of them. The Rural Hospital Transition Grant program is the right kind of program for rural hospitals. It is providing much needed, flexible assistance, directly to the communities that have both the needs and the responses to meet those needs. This money gets down right to where the rubber meets the road, and that is an important point. This program has resulted in a new wave of creativity, new relationships among providers and better services to Medicare beneficiaries and other rural residents. It is going to be interesting to see how this plays out in the future, as well.

The sole community hospital designation helps an increasing number of the most needy hospitals. That is a terrific program that really has played a big part. The essential access community hospital, rural primary care hospital, the EACH and RPCH program, may provide a reasonable alternative configuration for some hospitals that are not viable as acute care hospitals. You notice I said "may" because there are some problems with the design and perhaps with the implementation of the program. It could be made more useful, and I have included some comments in my paper.

Certified registered nurse anesthetist, CRNAs, are essential to rural hospitals' operation. The increased level of payment that you have approved now and in the future for CRNAs will really help rural hospitals stabilize that part of the work force even if it increases some of the costs.

The promise of the eventual elimination of the urban/rural differential in standardized Medicare payments was a significant acknowledgement that urban and rural hospitals should play on a level field. Further, the NRHA urges that the single national rate be a genuine one without the resource adjustments that have been discussed earlier, and we would like to see that change occur earlier than 1995 although we recognize that it is probably more important to stick to the budget plan than to do that. It is also important to note, though, that we are not just talking about a 7 percent differential. That the actual differences in what is paid to rural and urban hospitals—I have talked to systems that have both urban and rural hospitals—and they say it is in the 25 to 45 percent range, not 7 percent once it is adjusted. So it is a pretty serious difference, and it does make a difference for the operating margins of rural hospitals.

There are also some other problems. We certainly do not want to see our outpatient payments cut anymore, at least until the analysis by ProPAC is completed. We think that is really important. We are concerned about outpatient bundling, and we also have talked about several problems with the EACH and RPCH program that we would like to see addressed in the fairly new future.

We also continue to be concerned about a problem Congressman Lancaster talked about last year with disproportionate share hospital payments, and how the rural poor do not count quite as much as urban poor when it comes to getting disproportionate share payments. And we still have a lot of hospitals, rural hospitals that have high proportion of Medicaid that receive a much lower compensation under the disproportionate share hospital program.

In summary, Mr. Chairman, we are very happy about the past assistance that we have received from this committee that enables rural hospitals to meet the present day challenges in creative and useful ways. Rural people are creative people, and they rise to the challenge of the occasion. We ask your further assistance in helping us so that we can finish the job and protect the health care of rural Americans. Mr. Chairman, the National Rural Health Association and its rural hospital membership appreciates the opportunity to be here again, and we recognize what a difficult job you all have to do. If there is anything we can do to help, let us know. Thank you.

Chairman STARK. Thank you.

[The prepared statement follows:]

Testimony Before the
House Ways and Mean Health Subcommittee
by
Robert T. Van Hook, Executive Director
on behalf of the
National Rural Health Association
301 E. Armour Blvd., Suite 420
Kansas City, MO 64111
February 27, 1991

Mr. Chairman, members of the Health Subcommittee, it is again my pleasure to come before you to report on the status of rural hospitals. The National Rural Health Association and the nation's rural hospitals would first like to thank you for your support and fairness over the past year. We also welcome you, Mr. Stark, as the newest member of the House Rural Health Care Coalition. Thanks in part to your efforts, rural hospitals are doing somewhat better, but they are confronted by some old problems as well as new challenges.

Many of your actions have contributed to an increased ability of rural hospitals to develop creative solutions to the challenges they face in their communities. Allow me to catalog a few of them for the record.

- The Rural Hospital Transition Grant Program is the right kind of program for rural hospitals. It is providing much-needed, flexible assistance directly to communities that have both needs and responses to those needs. This money goes directly to where the "rubber hits the road." This program has resulted in a new wave of creative approaches, new relationships among providers, and better services to Medicare beneficiaries and other rural residents.

- The sole community hospital designation helps some of the most needy hospitals. It pays those hospitals on a fairer basis and provides some protection against erosion of capital and outpatient payments. But the program misses some very needy hospitals and it could be expanded and better targeted.

- The new rural outreach program, administered by the federal Office of Rural Health Policy, will provide additional incentives for rural hospitals to link up with other health care providers to find creative ways to extend their services into the community. This, again, is a program that goes directly to the community level.

- The Essential Access Community Hospital/Rural Primary Care Hospital (EACH/RPCH) Program may provide a reasonable alternative configuration for some hospitals that are not viable as acute care hospitals. You will notice I said "may." There are some problems with the design and implementation of the program that may make it less useful. More on this program later.

- Certified Registered Nurse Anesthetists (CRNAs) are essential to rural hospitals' operations. The increased level of payment, now and in the future, for CRNA will help rural hospitals stabilize that part of our work force, even if it increases our costs.
- Rural hospitals and doctors are pleased that Congress and HCFA have slowed down the process of implementing CLIA after having received an unprecedented mail response from the field. This hiatus gives rural providers a chance to figure out ways to deal with that very complex program.

- We are also very happy that the Congress reauthorized and expanded the National Health Service Corps. The number one problem in rural health is the shortage of primary care doctors. The shortage of physicians puts rural hospitals in a difficult negotiating position with doctors. The NRHA hopes that the Corps and physician payment reform will help in this critical area. However, the jury is still out on whether or not HCFA will follow the intent of Congress in physician payment reform. Further, these approaches alone will probably not solve the problem. There must be a better way to target direct and indirect medical education payments to support training in specialties we need (i.e., primary care, especially family medicine) and to institutions which have a demonstrated commitment to serving underserved populations. We have a couple of recommendations on this subject later in this testimony.

- The promise of the eventual elimination of the urban-rural differential in the standardized Medicare payments was a significant acknowledgment that urban and rural hospitals should play on a level field. Further, **NRHA urges that the single national rate be a genuine one, without additional "resource" adjustments, and we would like that change to occur this year, rather than in 1995 as planned.** It is important to note that the adjusted differential – based on what rural and urban hospitals are actually paid – is really in the 25 – 45 percent range.

Aside from these positive trends, there are lingering or emerging problems ready for further action by Congress:
- Medicare Part A budget cuts, especially for outpatient services, hurt rural hospitals disproportionately, because rural hospitals have taken the Congress' earlier directives and have moved more

rapidly into outpatient services. Last year, Congress approved a study by ProPAC on the impact of outpatient cuts on rural hospitals, and **the NRHA urges you not to cut outpatient payments to rural hospitals any further until you receive ProPAC's report.**

- In a related issue, **NRHA strongly opposes bundling of outpatient payments for physicians and hospitals.** Such a step would place small, rural facilities in the role of Medicare intermediaries, a role they have little capacity to perform. In addition, and very importantly, outpatient bundling would greatly upset the personal relationship between rural hospitals and their doctors and other health professionals.

- **Rural hospitals have great capital needs.** Rural hospitals tend to have much older physical plants than their urban counterparts. In North Carolina, for example, rural hospitals have average age of plant ratios that are twice the urbans'. Since rural hospitals have had little or no margins for the past 5-6 years, they have not been able to remodel or replace their plants, so any prospective system that is based solely on current capital costs will probably hurt rurals. HCFA's regulations on capital have just been released as this testimony is being written, so we have not had a real chance to analyze them. The NRHA will not "just say no." We will carefully study the capital regs, and make an independent evaluation of how they will affect rural hospitals. Our formal recommendations to HCFA will be forthcoming.

I can say, however, that the new regulations seem to be a serious and honest response to the policy you passed in 1987. From our initial reading we can see that some rural hospitals would do well under the program – at least in the short run. We are concerned, on the other hand, about: 1. how the "exceptions process" will be set up; 2. adjustments based solely on geography which repeat the mistakes of the past; and 3. the exclusion of rural hospitals which treat high proportions of Medicaid from preferential treatment accorded other disproportionate share hospitals.

- The EACH/RPCH Program has some serious flaws. First, it is important to recognize that the RPCH Program is very limited in scope and application. Contrary to popular belief, most small (under 50 bed) rural hospitals still have a significant inpatient load and responsibility. Secondly, the 6 bed limit on the RPCH is arbitrary and ignores significant fluctuations that can and do occur in most rural hospitals. What do we do with the sixth pneumonia case that comes into the RPCH? NRHA recommends that **the 6-bed limit be eliminated or changed to an average of 10 occupied beds.** Thirdly, the 72-hour stay limit is very problematic. It replaces medical decision-making with an entirely arbitrary limit. Do we transfer Grandma Jones out of the RPCH when she begins her fourth day of treatment for pneumonia or some other condition which the RPCH is fully capable of treating? The 72-hour limit was set to limit the complexity of cases that would be treated in an RPCH. It does not do that. NRHA recommends that **the 72-hour limit be replaced by either a DRG-based facility certification or a certification of the facility based on the RPCH's admission criteria.**

- The Prospective Payment System should provide incentives for urban referral centers to return patients to rural hospitals for recuperation and rehabilitation. Under PPS rural hospitals are currently paid a portion of the rural rate based on the average length of stay for the patient's DRG. The first day of stay is the most expensive. **NRHA recommends that the first day payment on transfers from urban hospitals be increased to at least equal the one-day rate for the urban facility and that incentives be implemented to encourage patients' return for recuperation and rehabilitation.** There are similar payment disincentives for transfers from rural facilities to urban facilities.

- Last year, Congress directed HCFA to perform a thorough review of regulations levied on rural hospitals. With all due respect, asking HCFA to perform the review independently is a little like asking the proverbial fox to count the chickens. This review is greatly needed. Such reviews have been conducted in California, with great benefit. Wisconsin and Michigan, too, have begun to consider a new licensing category – which they call "Rural Medical Centers" and "Rural Community Hospitals", respectively – which will recognize the highly diversified small rural hospital which make up the majority of rural hospitals. These new categories will be licensed with one visit from the state for all of the programs within the hospitals' service umbrella. **NRHA recommends that the scope of HCFA's review be extended to include home health, nursing homes, intermediate care, swing beds, hospice and other related programs, and that an independent panel of relevant organizations and rural hospital administrators be convened to advise the review.**

- Quality has become more than just an abstract process for all hospitals, and rural hospitals are no exception. Because their medical staffs are small, quality assurance presents special challenges for rural hospitals, often requiring them to link up with urban or rural neighbors to conduct their reviews. This is a good thing, but costly, and there is little technical expertise in how to conduct multi-institutional quality assurance review among independent facilities. **NRHA recommends that a small demonstration grant program be funded to test network-based quality assurance methods. Further, NRHA suggests that AHCPR be directed to study the comparative cost and outcomes of care for similar patients and conditions in urban and rural facilities.** Our nickel says that rural outcomes are better and costs are lower, as has been shown with a recent study of obstetrical outcomes in Washington.

- NRHA has testified previously about the inequities of disproportionate share hospital (DSH) payments between urban and rural hospitals. Rural hospitals are required to reach a higher percentage of Medicaid threshold in order to receive a much lower DSH adjustment. Why should the rural poor count any less than the urban poor? Why should a rural hospital with a high proportion of Medicaid load be compensated differently than an urban hospital? **NRHA recommends that the inequity in qualifying for and payments under the DSH Program be corrected to treat rural and urban hospitals equally.**

- As earlier mentioned, the number one problem in rural health is the shortage of health care providers, especially primary care doctors, more specifically family physicians, the backbone of the rural medical force. NRHA's and other association's publications are crammed with position vacancies. We are overwhelmed with requests for help in recruiting health professionals for rural communities. One respected "headhunter" has suggested that as many as 10,000 family physicians are being recruited in rural America. We are simply training too few primary care doctors and too many "ologists." This fact degrades rural health care and increases the overall costs that you have to face every year with the Medicare program. **NRHA recommends that graduate medical education payments be weighted for primary care residents and that undergraduate payments be weighted for schools that have a demonstrated commitment to and track record in training primary care doctors. Further, NRHA recommends that Medicare conditions of participation be changed to allow payments for emergency room services provided by mid-level practitioners.**

- Finally, the Professional Review Organization (PRO) Program is causing major headaches and increased unnecessary cost for rural hospitals. There are problems with unnecessary reviews, unclear standards, and inappropriate censures of physicians. Rural hospitals are as concerned with quality as anyone else, and this is not just a rural problem. However, because they are small and their medical staffs precious and precarious, rural hospitals are less able to respond to the constant requests of the PROs. Most of the citations from the PROs come to naught – they back off after being challenged or explained – but the cost and inefficiency of the process is great. Even when the PRO's citation doesn't stick, rural doctors and small medical staffs are often devastated by the process. They occasionally refuse to accept Medicare patients or retire from practice altogether. The PRO Program, as currently administered, is making a lot of lawyers and consultants wealthy at the expense of rural health care. **NRHA recommends that a thorough review of the PRO Program be initiated with significant input from the field.**

In summary, Mr. Chairman, our message is that we appreciate your past assistance in enabling rural hospitals to meet the present day challenges in creative and useful ways. Things are better than they were a few years ago, thanks in part to your help. Rural people are creative people, and they rise to the challenge of the occasion, whether it be a burning barn or a failing health care system. We ask your further assistance in clearing a level path for us so that we can finish the job and protect the health care of rural Americans.

Mr. Chairman, the National Rural Health Association and its rural hospital membership appreciates the gracious attention of this committee and the opportunity to speak before your again. We recognize the difficult job that you are facing, and frankly, I wouldn't want to be in your shoes. We thank you again for your efforts in the past, and we offer our assistance in the future.

Chairman STARK. Mr. Horty.

STATEMENT OF JOHN HORTY, PRESIDENT, NATIONAL COUNCIL OF COMMUNITY HOSPITALS

Mr. HORTY. Thank you, Mr. Chairman for asking me to testify. I appreciate the opportunity even though I know that much of our thoughts are not totally on this hearing. Mine certainly is not since I have a son Roger, in the Persian Gulf that I am more worried about perhaps than this hearing.

One point I would like to make is I believe that health care is not going to come out of the Persian Gulf the same. I believe that we are going to see real changes in this system as a result of the things that have been set in motion by what we are going through. Everybody has their own ideas of what will be done, and perhaps what must be done.

I believe that we have got to change the delivery system itself, and that much of what we have been saying this morning really goes to that issue. I think we have to deliver care, doctors and hospitals, together—not separately, with better quality, with more efficiency, to all Americans. And we have got to have less concern about making money.

I think hospitals can and must change to do this. I think hospitals are our primary asset at this point in time in this country to deliver care. We do not have any other. Public health is not what it was when I first came into this field. What we have to do is to use the assets we have, and use them efficiently, and I think hospitals can do this. I think there is enough creativity in the community hospitals of this country, that if we can begin to tap that energy, we can do many things.

We are not going to do it by spending a lot of time each year reallocating funds between various kinds of hospitals. We are going to have to do it by beginning to look at how we change the delivery system, and that means changing some of the legal difficulties that we have today. For example, if we are going to take resources from the center of our system, which is the community hospital, if we are going to have to allocate them elsewhere to rural, teaching, or inner city, which I believe is a bad idea, but if we do, then I think we have got to begin to free up community hospitals, especially in a two-hospital town to actively collaborate and to cooperate in delivering service. That is going to take some legal changes.

I would also add two other comments. The first is that the outpatient questions that were raised earlier by Congresswoman Johnson are very important, and particularly important in a situation where in a small town a doctor group with outside investors can put together an outpatient diagnostic clinic that can almost put the hospital out of business. I happen to be dealing with that particular situation at the present time in my legal practice. In this case, what we have is an absolutely unlevel playing field where the indigent care and the outpatient goes into the hospital, and the nonindigent care from the same physicians goes to a profit-making clinic.

And finally, I make one comment not totally facetiously, and that is that the true definition of an "efficient" hospital is a hospital without physicians. When we learn how to make the efficiency of the hospital and the efficiency of the physician make sense together, then we will not need to talk about a lot of the things we are talking about in this hearing this morning. That is our real challenge. Thank you.

[The prepared statement follows:]

STATEMENT OF JOHN HORTY, PRESIDENT, NATIONAL COUNCIL OF COMMUNITY HOSPITALS

My name is John Horty. I am President of the National Council of Community Hospitals ("NCCH"). NCCH is an organization of more than 100 hospitals and hospital systems operating more than 40,000 beds around the country.

Most relevant to this hearing is the nature of our member hospitals. They are community hospitals. NCCH represents its members not as rural hospitals, teaching hospitals, or large urban hospitals, although our members are all of these, but as mainstream community hospitals. The one distinguishing characteristic of our members is that their management is, we believe, particularly aggressive and innovative. Our members share a commitment to taking whatever management measures are possible under the current system to provide quality care in an efficient manner. They also share a commitment to develop new forms of health care delivery which will permit them to deliver care more efficiently than the present system does. I am here today to express our alarm about Medicare reimbursement, and also to urge that attention be turned to the more basic issues in health care.

Hospitals have become accustomed to the annual Medicare dance, and disturbed by it. The Administration, looking for budget savings, proposes reductions in the level of Medicare expenditures that are required to keep pace with medical inflation. Congress retains some, but not all, of these "cuts." Specifically identifiable sectors of the health care system make a case for adjustments to their particular reimbursement, and Congress reallocates some of the Medicare reimbursement in response to the loudest voices with the most immediate needs at the cost of the rest.

The 5-year budget agreement is, we hope, the climax of this process. Health care bore a substantial burden, but if the agreement is not changed, the pace of cuts and changes should slow. We are left, however, with the results of several years of the budget process and the provisions of the 1990 agreement which are still to be implemented.

PPS is a price control system. As is inevitable with any price control system, PPS will lead to shortages, anomalies, and dislocations. These consequences are exacerbated by a number of other circumstances that surround PPS. There is no agreed-upon standard for determining reimbursement; early promises that payment would keep pace with medical inflation have been cast aside. The system is now little more than a tool to help reduce the Government's general budget deficit and private photogenic budget "cuts." PPS, moreover, is being run not by an expert and objective body such as ProPAC nor even by an expert such as HCFA. It is being administered by Congress, which every year not only sets the reimbursement level as part of its overall budgetary decisions but makes a wide variety of reallocations in PPS reimbursement in response to its judgment of how health care resources should be allocated.

As ProPAC's reports demonstrate, even though Congress has rejected the full reductions sought by the Administration, the increases in PPS payments have been less than the increases in Medicare operating costs for every year that PPS has been in effect. And capital reimbursement has been by definition significantly less than allowable costs. Every year the distribution of even that constrained Medicare reimbursement is reconfigured by Congress, because of legitimate complaints, from particular sectors of the field. Every Medicare dollar that is reallocated to a specifically identifiable need comes from the undifferentiated hospitals who do not fit within any specific identifiable group, but are the general mainstream of community hospitals. Workers who pay their Medicare tax and who receive treatment in these hospitals are subsidizing through cost-shifting Medicare patients at hospitals which fall within the particular sectors which receive extra reimbursement.

These reallocations partially implement non-Medicare policies. Money is allocated through PPS to rural hospitals or disproportionate share hospitals to contribute to the survival of these hospitals for the benefit of non-Medicare patients as well as Medicare beneficiaries. Each of these reallocations appears appropriate; rural and urban hospitals should be supported. But we are in danger of using Medicare as a pot of discretionary money to address particular problems in the health care system. PPS is being used, in the absence of any other mechanism that permits such targeting, to channel funds to particular types of hospitals.

Before the trend becomes an ingrained habit, it is appropriate to consider whether it is appropriate to require certain Medicare beneficiaries and employees to assist non-Medicare patients. More immediately, this encroachment into Medicare reimbursement is unfair to community hospitals. They no longer can bear the drain on their Medicare reimbursement that results from the global cuts and then the reallocation of Medicare funds. When the Government reduces DRG payments to a hospital, it does not buy correspondingly less health care. Instead, the Government maintains the appearance of full coverage, and the patient still expects the same care; the hospital is bound by the legal requirements of Medicare, and by moral, professional, and malpractice considerations to provide it.

The hemorrhaging of Medicare reimbursement in recent years has taken its toll. ProPAC's data show that hospitals' PPS operating margins have decreased every year, and that by 1989 hospitals were losing money on Medicare patients. It now estimates an aggregate loss of 2.5% for 1990, and the loss no doubt has worsened since then.

At the same time that the losses on Medicare patients increase, hospitals' ability to cross-subsidize these losses from charge-paying patients is decreasing. The increasing and unevenly distributed burden of providing care to patients who have no public or private insurance or who under an inadequate Medicaid plan weakens hospitals' ability to withstand the Medicare shortfalls. Historically, hospitals have relied on patients covered by commercial insurance to cross-subsidize publicly supported patients. But this is rapidly diminishing. Patients covered by charge-paying indemnity insurance are being replaced by patients who belong to managed care plans which negotiate prices. Employers understandably are concerned about rising health care costs, and in response managed care plans are becoming more aggressive in their price negotiations with hospitals and less willing to make up hospitals' losses incurred in providing care to patients covered by other payors.

On the other side of the equation, hospitals' ability to reduce their costs is limited by inflation, by an increasingly aging Medicare population, by the development of new technology and new treatments and the professional imperative and financial incentives for physicians to use them, and finally by the overarching concern that failure to utilize new technology or provide the most recent treatments will result in a malpractice suit.

Our member hospitals have as aggressive a management style as any hospitals in the country and are as capable as any hospitals to make the needed management corrections. Nevertheless, almost all of our hospitals are now losing money on Medicare. Our members have reached a disturbing level of frustration with Medicare and concern for the stability of their institutions under the current reimbursement system. If, despite their strong management and the historical strength of their institutions, these hospitals are not able to provide Medicare treatment for what Medicare is willing to pay, it does not bode well for the field as a whole.

At the same time, I would like to emphasize that the solution to the problem is not simply to throw more money into health care. The need is to develop a more responsive and efficient system. Neither the health care system as a whole nor the Medicare system for financing care for the elderly is satisfactory.

Perhaps my greatest disappointment over the past seven years has been that the Government's overall budgetary problems and use of PPS as a tool for deficit reduction have precluded the needed debate on how the health care system should be organized and how Government assistance should be provided to assist people to pay for care. The energies of Congress and the Administration have been devoted to a numbers game, which is important in the short term but which entirely bypasses the main issues. In response, the energies of the field have been devoted just to trying to learn about the changes made in Medicare and attempting to adapt to them. The continued juggling of Medicare reimbursement creates a highly unstable environment which makes it extremely difficult for hospitals to plan and innovate. The attention the process has commanded each year has delayed the day when the fundamental questions are addressed. It has been a harmful diversion.

We believe that decisions on the delivery of health care should be made on a community-by-community basis. It is time to restore the center of gravity in the delivery of health care to each community and the surrounding area it serves. To redirect both the resources for delivering care and the delivery system itself, collaboration and cooperation between hospitals must replace increasingly useless competition. This will require the Congress to state this policy in a legal manner. If the hospitals of the community will have less resources, they must be able to work cooperatively. We are not asking government to provide local direction. Government has a dismal record of planning in this field. Hospitals in their community should be permitted to do the job, and they should be given the financial freedom and legal ability to do this. It can be done. Hospitals in various areas of this country are beginning to do just this. They need encouragement and the tools to do the job, not a system mesmerized by continuous reallocation of the same available funds.

The time bought by the budget agreement (at the risk of hospitals' financial stability) must be used to fix a system that is universally condemned. The important issues about the health care delivery system must be addressed now. I would like to suggest what those issues are:

1. We have no method by which society can decide how to allocate health care dollars in a global fashion. Hospitals should take a lead role, but both policy direction and adequate funding are necessary. More money should be devoted to prenatal care and childhood immunizations and other preventive measures. But reduction in Medicare payment for care provided to Medicare beneficiaries does not reach that result, even if that money is redirected to meeting public health needs. The hospital still has to provide the same care to Medicare patients. Instead of a reallocation of resources, the result is additive.

2. Who should receive Government assistance? Should, as is now the case under Medicare, beneficiaries receive the assistance without regard to need? It is time to face this issue, but only in concert with other issues. This requires

workers to pay for the health care of the retired rich. With respect to the employed population, should the tax system subsidize insurance equally for everyone? Should the Government provide tax incentives which benefit those who have jobs and particularly those with higher incomes or should the Government's tax subsidy be targeted on the basis of need? Should the Government through the tax subsidy encourage first dollar, comprehensive insurance, beyond real insurance needs?

3. Should Government provide assistance for all health care services or only for some? Should a determination other than only medical necessity be necessary for use of taxpayers' funds? Similarly, should there be a check on what health care services people can obtain, even if they pay for it themselves?

4. If these allocation decisions are to be made, who should make them? Should they be governed by market mechanisms or by political process? Should the decisions be made on a community-by-community basis? Should communities be allowed to determine the allocation of health care dollars spent in that community? If so, who in the community should make the decision and how should it be implemented?

5. Should there be a requirement that everyone have insurance? How should care for those who do not have insurance be paid for? Should it be paid by the patients who seek care where the uninsured go for care (and their insurers and employers), as is the case now, or should it be spread more equitably and more broadly across society? How do we decide what hospitals we need? Should those who provide the most uncompensated care be allowed to close?

6. What should the respective role of the various providers -- hospitals, physicians, nurses, freestanding clinics, nursing homes, etc. -- be? Does society want hospitals and other providers to cooperate with each other to reduce duplication in equipment and services?

7. We have no mechanism to determine how much health care resources should be allocated to an individual in a given case. We have not even decided if we want to address the issue as a society, yet hospitals and physicians face it every day -- and in the current climate usually have no choice but to provide care requested by the family, even if others may believe it is not socially appropriate to do so.

* * * * *

The physicians, nurses, administrators, and trustees who operate the health care system today are frustrated not simply by the Medicare reimbursement system, but by the lack of attention to health policy issues, and worse by the conflicting and often arbitrary policies which come from government. They are holding the health care system together and providing care while the system is being severely strained. They are under siege. They suffer from a lack of sufficient resources to provide the care demanded, and must administer a system that lacks cohesion, clarity, or, often, even rationality. They are frustrated by a system that does not match promises with resources and that has not sorted out what is expected from health care providers and from patients themselves.

Hospitals are on the front line. When government fails to resolve social problems, they end on the hospital doorstep. Yet hospitals themselves are beginning to represent the same failure of Government policy. They are being underreimbursed, regulated in often irrelevant minutiae, and subjected to conflicting requirements. What they need is stability and reliable funding, and, most importantly, they need resolution by this country of how it wants its health care delivery system to be operated. Our members will effectively manage whatever type of system society through Congress and state governments decides it wants, and they will provide the kind and level of care society wants. We ask only that our political leaders consider the basic questions, and that a national consensus on the health care system be developed.

Chairman STARK. Thank you, Mr. Horty.

Mr. Moody.

Mr. MOODY. That reminds me of a joke I heard the other day. Definition of a normal person is someone who has not yet been fully examined at a university hospital. Mr. Rettig, you noted previously that hospital expenditures have remained as a constant share of GNP. I have read your testimony. I did not hear all of it. Is it not true, though, since 1982 hospital expenditures constant share of GNP do not include expenditures for outpatient care?

Mr. RETTIG. That includes hospital outpatient services so that we are dealing with both inpatient and outpatient.

Mr. MOODY. Right.

Mr. RETTIG. Now it is also true that it includes some services that once might have been provided by us; but a lot of patient services have escaped into the broader physician community.

Mr. MOODY. Right. When taken together they have grown at the same rate? They have kept a constant share of GNP?

Mr. RETTIG. That is correct.

Mr. MOODY. Which is about what?

Mr. RETTIG. About 4.2, 4.3 percent.

Mr. MOODY. So that we keep hearing the share of GNP is growing for all health care services taken together. But it has not been the hospitals which have been growing as a share?

Mr. RETTIG. That is correct. Our share has remained relatively constant while the others have grown.

Mr. MOODY. On the inpatient side, since admissions have been coming down for a variety of reasons, should not that number actually have declined, or has it been a one for one shift into outpatient? Because there have been fewer and shorter stays in hospitals. We all know that.

Mr. RETTIG. I think we had some testimony earlier that indicated on the inpatient side, the share of the GNP attributable to that has gone down.

Mr. MOODY. Why would it have been matched dollar for dollar for outpatients? I mean since the cost of inpatient is more cost intensive than outpatient; right? Inpatient is more cost intensive than outpatient. Inpatient has been going down. So outpatient must have been going up at a rate faster than the inpatient is coming down in order to compensate to hold it even as a share.

Mr. RETTIG. Outpatient costs have been rising very rapidly. I think there was some brief discussion of this earlier this morning also. And the reports are not fully in. In other words, people cannot fully figure out how much of that is transfer from inpatient to outpatient side and how much is something else is going on. I would say that part of it that there is an additional use of services related to the fact that medical technology has made some things less painful, less risky, less time-consuming than they once were, and they now occur in the outpatient department, whereas in some cases they might not have occurred at all before.

Mr. MOODY. But I guess my question was given the technology which allows people to go home sooner, not just switch from in to outpatient, but also even to go home, would we not have expected total share of GNP to come gradually downward?

Mr. RETTIG. For all medical care?

Mr. Moody. For all hospital in and outpatient. Unless you believe that the outpatient has been growing so rapidly as to soak up all that savings on the inpatient?

Mr. Rettig. I mean I think that is the phenomenon we are looking at that the outpatient utilization and costs taken as a whole have risen rather dramatically, enough to keep the total inpatient/outpatient constant with the GNP.

Mr. Moody. Right.

Mr. Rettig. We are not sure about all the details of why that has happened.

Mr. Moody. OK. You mentioned in your testimony that hospitals have had to close needed community services due to the perceived gap between PPS, Medicare revenues, and the associated costs. You mentioned, I think, trauma care and obstetrics. But is it not true that Medicare would be almost irrelevant? I mean Medicare does not use obstetrics, and it does not use much trauma care.

Mr. Rettig. Medicare is involved with the trauma care, of course.

Mr. Moody. Some, but not——

Mr. Rettig. But typically not with obstetrics. I think we are just talking about Medicare's contribution to the overall financial pressures that hospitals are feeling. And we are saying that that is becoming a pretty significant to the point that total patient margins are now negative, not just Medicare.

Mr. Moody. Right. But isn't the closing of some of those services not really very related to Medicare. Would they not often be more related to indigent care, unsponsored care?

Mr. Rettig. That is part of the whole picture of the financial pressure that is coming on hospitals.

Mr. Moody. So Medicare used to, in effect, cross-subsidize unsponsored care, and it is not doing so anymore; is that another way of expressing what you are saying?

Mr. Rettig. I think you can say that Medicare's approach that involves prospective payment and a more rigorous look on the outpatient side as well corresponds with what other payers have been doing as well. All of them have been trying to make sure they do not pay for anybody else's patients except their own. The combined effect of that means that hospitals do not have anyplace else to go. We are at the point now where if we were going to, if hospitals in the aggregate were going to recover from Medicare/Medicaid underpayments, uncompensated, or unsponsored care, they would have to increase their charges to the remaining private payers by something like 20 percent. To the extent that private payers have market power, they are not going to let that happen.

Mr. Moody. If I could ask just one brief question. Let me just ask for a one sentence or one word answer from each of you. Do each of you, each of the four panelists here, feel that Medicare, not Medicaid, is paying less than variable costs on your cost ledgers, or is it covering variable costs, as far as you can tell, as opposed to capital costs?

Mr. Van Hook. I cannot answer that.

Mr. Moody. You do not know?

Mr. Van Hook. No, sir.

Mr. Moody. No idea?

Mr. **Rettig**. As has been said earlier, we do not have those figures.

Mr. **Gradison**. Intuitively, in many urban public hospitals, I think the answer would be "yes."

Mr. **Moody**. That they are covering variable costs?

Mr. **Horty**. Yes, that is my intuitive answer, too, yes.

Mr. **Moody**. But it is based on intuition, not hard numbers. Thank you, Mr. Chairman.

Chairman **Stark**. Mr. Cardin.

Mr. **Cardin**. Thank you, Mr. Chairman. I would like to get your views, any one of the members of the panel, but particularly you, Paul, on the PPS system. When you look at the figures that we have available for 1982 and compare it to the most recent figures of 1989 that are available, you look at the occupancy rates of hospitals and how hospitals have fared under the PPS system, you find occupancy rates in 1982 were 75.3 percent, in 1989 they are 66.1 percent. Full-time equivalent personnel per occupied bed has gone from 1982 of 4.3 to 1989 of 5.3. Percentage of hospital budget spent on capital in 1982 was 6.5 percent. That has gone up to 8.7 percent indicating there has been some shifting.

But what is really alarming is that you look at the payments per patient and it has gone up basically two times the CPI rate of increase during that same period indicating that hospital costs have increased much higher than CPI. It looks like the efficiencies of hospitals have declined during this same period of time if you look at the number of personnel and the occupancy rates. Could one then assume from what I am saying and would the statistics indicate that PPS has failed in regards to hospitals on reimbursement systems? Paul, do you want to?

Mr. **Rettig**. To start with, the conclusion you seem to have reached that PPS has failed in controlling hospital costs, I would say not so. Let me take some of these points one by one. Occupancy is a reflection of, the level of occupancy is a reflection of many factors, but not the least of it is the trend which everyone hoped would occur which is the transfer of care out of the inpatient setting. To some extent, then we were left with——

Mr. **Cardin**. But at the same time we see capital costs increasing, which would tend to reflect that you are building more.

Mr. **Rettig**. You have seen them expressed as capital cost per occupied bed. And I guess what I would say is—I am sorry—capital costs as a percent of the total is, as for the last several years, at about somewhere between 8 and 9 percent and has remained flat. So——

Mr. **Cardin**. In 1982 it was 6.5.

Mr. **Rettig**. And as Dr. Altman said, it even appears to be declining relative to the total.

Mr. **Cardin**. Well, in 1982, it was 6.5 percent.

Mr. **Rettig**. So overall. I would be glad to get back to you with something other than an off the cuff analysis of that, but I would assume that part of it reflects the fact that hospital care has changed to some degree and has become more capital intensive.

Mr. **Cardin**. So your conclusion is the PPS system has reduced costs even though the costs have gone up twice what the CPI has over this period of time, and even though hospital costs in this country are increasing faster than other countries?

Mr. RETTIG. That is in comparison with what might have otherwise happened. In other words, I think PPS still has had a significant effect.

Mr. CARDIN. It seems like a strange standard for judgment. But I mean you are saying it could have been a lot worse?

Mr. RETTIG. I think that is right, and I do not want to be in a position to say that there is no cost problem. In other words, we are all kind of agreeing that there is a cost problem in the health care field generally, and although hospitals as a percentage of the total have been doing better than the rest, they still represent a major part of the total, and so they all deserve scrutiny.

Mr. CARDIN. Of course, the second part is efficiencies. And these statistics seem to indicate a lack of efficiencies also under the PPS system?

Mr. RETTIG. As has been said earlier, this is hard to measure. You heard the two economists who have somewhat different views on that in the preceding panel, and the figures can be presented in a variety of ways. For example, full-time equivalents, if you look at per case, have remained basically flat notwithstanding that for adjusted admission is technically what it is which encompasses some of the outpatient side, but has basically remained flat.

Mr. CARDIN. Thank you very much.

Mr. MOODY [presiding]. Mr. Gradison.

Mr. GRADISON. Thank you, Mr. Chairman. Mr. Rettig, we began today's testimony, we began today's hearings with testimony by Dr. Altman in which he indicated, and I am reading, the decline in total margins of hospitals has now leveled off and remains at about the same level as immediately before PPS. Total margins today, he went on to say are considerably higher than they were at any time during the 1970s. Now in your summary, your first paragraph of your summary, you say hospitals have responded positively to the incentives of the PPS system, and yet are in precarious financial condition. Are both these statements correct?

Mr. RETTIG. They can be viewed as consistent with each other. From our point of view, you are looking at a period before prospective payment and before there were a lot of financial pressures on hospitals through aggressive purchasing. What you now have is a situation in which there is an element of risk whereas before you got cost reimbursement, some of it was deliberately set so that there would not be a positive margin. Theoretically, one way to view cost reimbursement is it produces zero margin. So you have the security of a cost reimbursement world with relatively lower margins. Now you are in a riskier environment.

The second thing is that we are talking about total margins, not just patient care margins. Our concern is that those are things that hospitals have scraped together to keep themselves whole in many cases and sometimes have been criticized for doing it. To some degree that represents business ventures. That represents contributions. It represents, it includes the tax support for publicly funded hospitals. In other words, and that is not counted as patient care, and includes a variety of that kind of stuff which we are concerned may not be reliable and trustworthy for the long run. In other words, it is just not as dependable, and hospitals, therefore, feel vulnerable, believe it or not, even though when you look at those margins you see that, as has been stated, that the total margins are like they were in the 1970s.

Mr. GRADISON. So we are doing OK now, but we are worried about tomorrow; is that it? I know there are some hospitals that are in bad financial shape. That I understand. But you represent the industry as a whole.

Mr. RETTIG. Yes. When we look—and it is difficult because we are dealing with averages. Some institutions are doing extremely poorly. Some are doing quite well. On the average we are looking at patient care margins that have now turned negative. So that if you say, "what do I collect for patients in return for the care I provide," you are losing money. And it is being paid up with this other stuff which is interest on cash that is held, the contributions, some Government funding, and so forth, which we think is a different kind of a thing.

Mr. GRADISON. It might be more predictable than—the parking lot revenue may be more predictable than the patient revenue. Well, I say that, the reason I say that is that I have been struck over the years at home how, I can remember a time when Government contributions to the operations of social welfare agencies including hospitals, including medical research, were considered hard dollars. Now they are considered the softest of the soft dollars, literally because they are so unpredictable. And locally derived funds, funds from contributions and funds from the gift shop and the parking lot are actually considered harder, somewhat more predictable than what comes in from the Government.

I do not mean that is a happy situation. But I think you can appreciate, because you know the calculus we go through around here, why we look at the total margins—I mean the net margins on total operations as well as net patient revenues as well as Medicare margins to try to get an overall picture of what is going on.

Mr. RETTIG. We can tie that back into the earlier discussion today about what is Medicare's responsibility with regard to the overall financial situation of hospitals or of health care institutions generally, and you can look at it in a variety of ways as has been mentioned today.

Mr. GRADISON. Yes. I mean where I come out on that is that we probably are doing the right thing to look beyond just Medicare beneficiaries to the extent we have got money to work with. But if we attempt to restructure Medicare payments out of this fixed pool of dollars to solve all the problems of the health care system or even the problems of Medicaid, we will probably screw them both up in the process. Both Medicare and Medicaid would probably be losers. I mean that. I think there is a delicate balance involved in the decisions that we make where there is a judgment call.

I have thought at times there was an attempt to go too far in that direction, but in honesty when I look at the numbers and listen to you and read Stuart Altman's reports, I think we have done a pretty good job overall considering the resources we have to work with. I am not trying to pat ourselves on the back, but I do not look at it and think that the scorecard is all that bad. Thanks, Mr. Chairman.

Chairman STARK. Thank you. I want to thank the panel. I get a sense, and I do not mean to put words on the record for the witnesses, but that Mr. Van Hook and Mr. Horty would probably agree that if we had to pick one existing system, we ought to take capitation or an HMO to provide the care in the most efficient way. Is that fair? I say if you had to pick an existing system. You might like to create a whole——

Mr. HORTY. Yes, with a big but. And the big but is if they were efficient as well. If the HMO was efficient.

Chairman STARK. Well, some are, and some are not.

Mr. HORTY. Some are and some are not.

Chairman STARK. I happen to come from a district where Kaiser is arguably very efficient relative to resource utilization.

Mr. HORTY. I think you are on the right track.

Chairman STARK. Yes. But they are an institution. That is 50 years of being in the same community, and there is an institutional spirit that is grown, and I do not know how you legislate that.

Mr. HORTY. There are some very small HMOs, one in Newark, Ohio.

Chairman STARK. Marshfield, Wisconsin.

Mr. HORTY. Yes. The Newark, Ohio, HMO is very efficient with 8,000 people, and there are awful HMOs with 150,000 people.

Chairman STARK. Yes. In some cases, we still have not been able to arrest the perpetrator of those, if we can find him. I cannot resist, Paul, just suggesting that your chart there might have been mislabeled. What you really meant is hospital administrators cannot keep costs down? Is that not what you wanted to say instead of we did not keep payments up? I did not quite know which line you thought we were responsible for there, but——

Mr. RETTIG. This is to some degree in the eye of the beholder.

Chairman STARK. That is right. And I also wanted to argue with Mr. Horty a bit on page 3. You make a statement in there that increases in PPS payments have been less than the increases in the operating costs for every year that DRGs have been in effect. Are you talking about the marginal increases there or the total? OK. Because I do not have that chart. We have been paying more except in the last 2 years. I do not have the information on the increases.

Mr. HORTY. Yes, the payment per discharge is less per year than the operating expenses per discharge. But I would say this, and that is, I have said this before so I am not saying anything new. I believe that with the exception of increases for inflation, we have got enough money in this system to do the job. It is just maldistributed. It is badly operated. And it is not the fault of any one sector, either the Government or the hospitals or the physicians. It is the delivery system itself does not work anymore, and we are going to have to change it.

Chairman STARK. I agree. But I am faced with a political problem.

Mr. HORTY. I understand.

Chairman STARK. For the record, I would also like to include, without objection, a statement by Martha McSteen, president of National Committee to Preserve Social Security and Medicare.

[The prepared statement follows:]

STATEMENT OF MARTHA McSTEEN, PRESIDENT, NATIONAL COMMITTEE TO PRESERVE SOCIAL SECURITY AND MEDICARE

I am Martha McSteen, President of the National Committee to Preserve Social Security and Medicare. I appreciate the opportunity to express viewpoints from the five million member organization. As Medicare beneficiaries, National Committee members have a clear and direct interest in the Administration's proposal to further reduce the Medicare hospital budget.

In spite of Medicare taking the brunt of budget cuts last year with a $44 billion cut over five years, the Administration has returned with requests for further cuts. It is a breach of agreement to come back this year with proposals to reduce Medicare by another $25 billion over the next five years. The essential Medicare program cannot continue to be the target for cuts.

Under the Administration's proposal, hospitals are asked to take 66% of the proposed Medicare cuts. Considering that this cut would be on top of previous years' reductions, the question must be raised as to how much hospitals can cut back before there is a more direct impact on beneficiaries. Hospitals today care for patients with major health problems. These patients require more tests frequently by expensive high technology equipment. Severely ill patients require more professional and support staff, not less. Even with increased efficiency, there is a limit to what the staff can manage before quality of care is seriously affected.

The Administration is proposing particularly severe cuts in indirect graduate medical education. Clearly hospitals with medical education programs have higher costs than other hospitals. They are located in urban areas where they serve a poor and aging population. Furthermore, due to the teaching environment there is a higher staff to patient ratio, intensified tests and other treatment. The Administration proposes to reduce the current Medicare adjustment factor of 7.7% to 4.4%. While the National Committee is not in a position to judge what is an adequate reimbursement to support the special job of teaching hospitals, we find it interesting that the nonpolitical Prospective Payment Assessment Commission recommends an adjustment factor of 7%. This is much closer to the current adjustment factor than the Administration's proposal. Reducing the teaching adjustment could seriously jeopardize the overall financial condition of major teaching hospitals.

The administration also proposes to reduce the total reimbursement for direct graduate medical education. Direct graduate medical education helps hospitals pay for classrooms, instructors, salaries, benefits, malpractice insurance and stipends for medical students. The proposal calls for using a lower base for calculating reimbursement to hospitals. At the same time a proportionately higher reimbursement for primary care residents would be used as an incentive to encourage the training of primary care physicians.

While the National Committee supports the idea of encouraging students to pursue primary care medicine, we question whether the Administration's proposal will result in that laudable goal. Reducing direct graduate medical education is no way to encourage the training of either primary care doctors or specialists. There is also no reason to believe that medical students will pursue primary care medicine just because the hospital is reimbursed more for their residency.

We are extremely concerned about the long-term implictions of these budget driven proposals on access and quality of care. In recent years, federal government reimbursement policies have made it increasingly difficult for health care professionals and their institutions to provide needed Medicare services to seniors, the disabled and the poor.

In conclusion, the National Committee strongly opposes the Administration's proposed cuts in Medicare--both out-of-pocket cuts and provider cuts. While the focus is on the importance of graduate medical education, we also urge Congress to insure that geriatric medicine is an integral part of the training Medicare is paying for.

Chairman **Stark**. We were talking here about Alameda County, part of which I represent, in which there are 1,200,000 people, and I am just going to estimate that 200,000 of those people are either in MediCal, in Federal veterans hospitals, or uninsured. And we know that Kaiser takes care of a half a million people, and the fee-for-service community takes care of the other half a million.

You can get as many arguments in Alameda County as you want on either side of the issue as to whether Kaiser's care is adequate or inadequate. People love it, would not go anyplace else, and people, largely those who have never participated in it, hate it. But the number of hospital beds per thousand is far, far lower with Kaiser. The number of physicians per thousand is far, far lower. The number of primary care physicians is far lower and arguably, from everything we can determine the care is excellent.

But the political problem comes, as I have indicated, when I suggest to my mother that she might like to sign up with Kaiser. She suggests that she will go out publicly and sleep on a grate in order to humiliate me before she will leave quote "her doctor." Now that is the political problem that we face.

We might among the economists and the technicians dream up an efficient system, but I am not sure we would sell it to the American public. And so I keep looking at how we can include the people in our system that are not in it at all, and then see how we work together as you all suggested to make it more efficient. And that is what makes our job interesting, and I might add it is your help in this area that we appreciate. You bring to it some different problems and some different perspectives, and if we cannot get some consensus among you and the constituencies each of you represent—we are arguably more sophisticated in this than the general public—we got real trouble. To that end, I thank you and look forward to working with you on this problem over the rest of this year and years to come. Thanks a lot.

[Whereupon, at 2:05 p.m., the hearing was adjourned.]

[Submissions for the record follow:]

STATEMENT OF THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES

The Association of American Medical Colleges (AAMC), which represents all of the nation's medical schools, 92 faculty societies, and over 350 major teaching hospitals that participate in the Medicare program welcomes the opportunity to submit testimony on the Administration's Fiscal Year (FY) 1992 budget proposal for Medicare hospital payments. In federal fiscal year 1989, nonfederal members of the AAMC's Council of Teaching Hospital (COTH) accounted for nearly 2 million Medicare inpatient discharges.

The Administration's budget proposals would reduce the growth in the Medicare program expenditures by $2.8 billion in FY 1992. Payments for hospital inpatient services under Medicare Part A provisions would be reduced by over $2 billion in FY 1992. Of that amount, more than half or over $1 billion would be saved by targeted reductions in graduate medical education payments to teaching hospitals. While all of the Administration's health care budget proposals are of concern to the nation's hospitals, three proposals to change Medicare payments are of particular concern to teaching hospitals:

- The reduction in the Medicare indirect medical education (IME) adjustment in FY 1992 from 7.7 percent to 4.4 percent.

- The proposed change in Medicare direct medical education (DGME) payments from a per resident payment amount that includes the full range of allowable costs to a per resident amount derived from the national average resident's salary. Three differential weighting percentages are then applied to the base salary amount depending on the resident's specialty choice.

- The proposed change in hospital outpatient payments, which would base ambulatory surgery, radiology, and diagnostic tests provided in the hospital outpatient department on prospective rates.

Each of these proposed changes would result in a substantial reduction in Medicare revenues for teaching hospitals. Collectively, the resulting decrease in revenues caused by these proposals would seriously threaten the financial stability of teaching hospitals, affecting access to care and quality of care received by Medicare beneficiaries and other patients.

The Administration's proposal to reduce the IME adjustment from 7.7 percent to 4.4 percent is the number one Medicare savings option reducing the IME adjustment in excess of $1 billion in FY 1992. Although this reduction accounts for approximately one half of the Medicare Part A savings, the Administration's DGME payment proposal is a policy issue of major concern to the AAMC. Graduate medical education rests upon a relatively fragile interweaving of multiple institutional capabilities, individual goals, and personal initiative. It is a system that could easily be damaged unless any changes to it are carefully crafted and are based on an extensive understanding of both the nature of teaching hospitals and of graduate medical education itself.

DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS

In addition to providing care to individual patients, teaching hospitals provide the resources for the clinical education of physicians, dentists, nurses, and allied health professionals. To provide this experientially-based clinical training, hospitals incur educational costs related to patient care. These added costs include resident stipends and benefits, salaries and benefits for faculty supervision of trainees, classroom space, supplies, clerical support, and allocated overhead. Medicare has historically shared in the costs of these approved education activities on a reasonable cost basis. The Medicare program makes a payment to teaching hospitals for its share of allowable direct health professions education costs which is separate from and should not be confused with the purpose or methodology of the IME adjustment in the prospective payment system. The present system for graduate medical education and its financing has much to commend it. The existing system of residency and fellowship education is marked by several fundamental characteristics:

- It is organized primarily in hospitals;
- It has been focused mainly on inpatients, but involvement with ambulatory patients is rising;
- It has responded to the growth in medical school graduates to provide training positions for all graduates of medical schools accredited by the Liaison Committee on Medical Education (LCME) and for numerous foreign graduates;

- It is fundamentally a system in which the mix of specialties and geographic distribution of fully trained clinicians reflects the sum of decisions made by program directors, hospitals, affiliated medical schools, and trainees;
- It has been funded primarily by patient services revenues, with significant appropriations supporting some municipal- and state-supported hospitals and all military and Veterans Administration hospitals; and,
- It is a system of learning by participation in the care of individual patients and, therefore, includes elements of both education and service.

These characteristics have produced a relatively strong and stable system of graduate medical education. However, there are five major factors that characterize the current environment for graduate medical education:

- The number of fully trained physicians in practice has increased substantially both in absolute terms and in relation to the general population;
- In the past two decades, the number of primary care specialists has grown more rapidly than the population. However, the number has not grown as rapidly as the number of physicians in other specialties;
- In the face of growing physician supply and pressure to restrain health care expenditures, public and private third-party payers are adopting payment systems that limit or even fail to earmark payments for graduate medical education;
- As hospitals encourage shorter stays by more acutely ill patients, training in ambulatory and long-term care settings will need to supplement the educational experience provided in hospitals to assure that residents receive comprehensive clinical training; and,
- As hospitals are increasingly pressured to improve efficiency, the mixed educational and service roles of residency programs will be under constant pressure to emphasize service.

Residency programs require long-term, stable funding commitments to provide an appropriate education and to enhance the quality of patient services. The program must recruit faculty, develop educational processes, and sustain an organizational commitment to maintaining a stable educational environment in the midst of an often hectic patient service setting.

DGME - Medicare's Current Financing Role

The passage of the Consolidated Omnibus Budget Reconciliation Act (COBRA) (P.L. 99-272) in 1986 changed the method of payment for direct graduate medical education costs and placed restrictions on Medicare reimbursement for physicians in graduate medical training (residents). Intended to limit the amount of direct costs that could be "passed through" to the Medicare program, COBRA requires the calculation of a hospital-specific per resident amount, based on the 1984 or 1985 cost reporting year and updated by an inflation factor. Each hospital's per resident amount is determined by dividing its allowable base year costs by the number of full-time equivalent (FTE) interns and residents at the hospital during that base year. The per resident amount is then updated for inflation and multiplied by the number of FTE interns and residents in the hospital complex in the payment period. Residents are weighted at 1.0 FTE for the residency period required for initial board certification plus one year, not to exceed a total of five years. Beyond the lesser of these two limits, residents who remain in approved programs are to be weighted at .5 FTEs. Medicare's share of the aggregate payment amount is based on the ratio of Medicare inpatient days to total inpatient days. The AAMC did not oppose this payment change.

These per resident payments are effective retroactively to July 1, 1985. Audits are currently being conducted to determine whether the hospital has been appropriately reimbursed for its Medicare DGME costs. Because the audit instructions were published 5 years after the change in the law and some institutions have been assessed with substantial overpayments, OBRA 1990 prohibits DHHS from recouping any overpayments during FY 1991. Beginning in FY 1992 and during the next four years, the secretary may not recoup more than 25 percent of the total amount of the overpayment in any one year. Although COBRA limits payments of allowable direct medical education costs, it still acknowledges the historical scope of direct medical education costs, including the salaries and fringe benefits of residents and supervising faculty physicians and institutional overhead costs.

The Administration's FY 1992 DGME Budget Proposal

The proposal in the Administration's FY 1992 budget document is stated as follows:

> Base graduate medical education payments on the national average salary of residents. Pay 240 percent of this figure for primary care residents, 140 percent for non-primary care residents in their initial residency period, and 100 percent for non-primary care residents beyond this period.

The Administration's FY 1992 DGME proposal is similar to the Administration's FY 1991 DGME proposal. The Administration believes its proposal will decrease the present diversity in DGME payments that has resulted from the historical patterns in hospital financial support and accounting differences. The Administration also believes this proposal will increase the supply of primary care physicians in the United States by providing favorable payment amounts for primary care residencies, and substantially less favorable payment amounts for all other residencies. The Administration's proposal does **not** define primary care residency programs and it does **not** indicate the national average resident's salary.

To estimate the impact of this proposal for AAMC membership, it is assumed that the national average resident's salary is **$28,894**. This is the 1990 average salary/stipend for the 3rd Post-MD Year based on the COTH Survey of Housestaff Stipends, Benefits and Funding, 1990. After adjusting for inflation, the FY 1992 national salary is **$31,281**. Three differential weighting percentages are then applied to this amount (**$31,281**) depending on the resident's specialty:

- $31,281 x 240% = $75,074
Primary Care residents would be weighted at 240 percent of the national average resident salary.

- $31,281 x 140% = $43,793
Non-primary care residents in their initial residency period would be weighted at 140 percent.

- $31,281 x 100% = $31,281
Non-primary care residents beyond the initial residency period would be weighted at 100 percent.

AAMC Reasons for Opposition

The AAMC strongly opposes any legislative changes in the current payment system for direct graduate medical education payments for the following reasons:

- The Administration's proposal, with estimated savings of $140 million in FY 1992, is an aggregate reduction in DGME payments. Based on AAMC 1989 data from 155 COTH Member hospitals, adjusted for inflation using the Consumer price index, the estimated **average** per resident cost in 1992 is **$69,923**.

The AAMC believes the Administration's proposal to make payments based solely on residents' salaries, thus reducing Medicare's funding of graduate medical education, is an inappropriate public policy. Graduate medical education is based on the premise that residents learn best by participating, under supervision, in the day-to-day care of patients. Residents are major contributing members of the professional team that cares for patients and ample supervision is necessary to monitor appropriately residents' development in an environment of rapidly changing practice patterns. The Administration's proposal to change DGME payments would certainly result in reduced payment for the costs of supervisory faculty salaries and benefits. Reduced support for supervising faculty would have a significant adverse effect on the quality of both patient care and residency training programs in the nation's teaching hospitals. Recent public and media attention to the issues of residents' supervision and working hours has led to state governmental as well as voluntary accreditation efforts to set more explicit requirements for supervision and to restrict residents' working hours. Supervising physicians must judge the clinical capabilities of residents, provide residents with the opportunities to exercise progressively greater independence, and ensure that the care of patients is not compromised. This supervising responsibility requires substantial time and commitment, and must be compensated. The AAMC believes that all third-party payers, including Medicare, must support their proportionate share of the costs of supervision and other related educational costs to help ensure high quality patient care, and to preserve the high quality of residency programs.

- The regulations implementing COBRA 1985 were published in the September 29, 1989 *Federal Register* and are currently being implemented. Final audits of the base-year costs were scheduled to be completed by February 28, 1991. The Administration's proposal would reduce graduate medical education payments at a time when the effects of the COBRA 1985 changes remain uncertain. Payments would be "indexed" at a time when the base payments are not finally determined.

- The Administration's proposal assumes a relationship exists between medical student specialty choice and hospital per resident payments. This premise is flawed. Medical students' selection of residency training programs is not affected by Medicare payments to hospitals.

- The Administration assumes there is a shortage of primary care residency **positions**. This is inaccurate. Data from the 1990 National Resident Matching Programs (the Match) show that primary care residency positions are available, but that medical students are not selecting these positions. If the objective is to produce more primary care physicians, then the issue is how to encourage medical students to select primary care residency positions. Data from the 1990 Match show:

    - 64 percent of the "primary care" internal medicine residency positions were filled by graduates of U.S. medical schools. If foreign graduates are included, then the number of filled positions increases to 85.6 percent.

    - 46.3 percent of the "primary care" pediatric residency positions offered were filled by U.S. graduates. If foreign graduates are included, then the number of filled positions increases to 80.5 percent.

    - 59.3 percent of the family practice residency positions offered were filled by U.S. graduates. If foreign graduates are included, then the number of filled positions increases to 70.4 percent.

Medical students' failure to choose primary care residency training is not based on the unavailability of residency slots in these specialties or on the level of hospital payment. Their reasons for choosing specialties other than primary care are complex and only partially understood, but are based on a combination of personal and professional factors.

While strongly supporting more individuals entering primary care, the AAMC does not believe this result can be achieved by manipulating hospital payment. On the contrary, personal incentives such as loan forgiveness, tax benefits, and other inducements are more likely to result in greater numbers of U.S. medical school graduates to enter the primary care disciplines. If monetary incentives are to be provided, they should be aimed at individuals, not hospitals and their sponsored residency programs.

- If the Administration's proposal is adopted, it is likely to cause divisiveness within the institution among different departments and divisions. Those disciplines with an increased weighting factor will argue that they deserve "more" of the DGME funds for their residency programs. It is very likely that these programs already receive more supervisory salary support for education. At the same time, pressures from other disciplines will most likely be forthcoming for more faculty salary support. As set forth in an **"AHA News"** article dated Oct. 15, 1990, Arthur Boll of Deloitte & Touche says, "No matter what approach is taken, physician specialists who lose out under the RBRVS fee structuring are likely to expect hospitals to pick up the difference. Hospitals might hear physicians asking for more academic support, or physicians may want to be compensated for the supervision and instruction of residents in graduate medical education."

- Supporters of the Administration's proposal have stated that the payment differential will be enacted only to make higher payments to the primary care disciplines. Many medical disciplines will argue that they deserve an increased weighting factor. The AAMC notes that emergency medicine was added as a primary care category to the House Ways and Means Committee proposal last year, and physical medicine and child psychiatry immediately made a case for inclusion.

The historical characteristics of graduate medical education, coupled with changes in physician manpower supply, pressure from both federal and private payers to constrain the growth in health care expenditures, and changes in medical care delivery have produced significant tensions for residency and fellowship programs. Proposals to yet again alter Medicare payments for graduate medical education contribute to instability and are detrimental to the nation's medical education system. Strong residency programs require continuity of effort and stable support. If future generations of Americans are to have appropriate access to well-trained physicians, we must continue to maintain and strengthen our medical education system, including its residency training component.

INDIRECT MEDICAL EDUCATION ADJUSTMENT

In addition to producing primary, secondary, and tertiary patient care, teaching hospitals provide an environment for biomedical research and medical education. Congress has recognized that the additional missions of teaching hospitals increase their costs and has supplemented Medicare inpatient payments to teaching hospitals with the indirect medical education adjustment in the PPS system. However, the IME adjustment is mislabeled and frequently misunderstood. While its label has led many to believe this adjustment to DRG prices compensates teaching hospitals solely for education, its purpose is much broader. Both the House Ways and Means and Senate Finance Committees specifically identified the rationale behind the adjustment:

> This adjustment is provided in light of doubts...about the ability of the DRG classification system to account fully for factors such as severity of illness of patients requiring the specialized services and treatment programs provided by teaching institutions and the additional costs associated with the teaching of resident...the adjustment for indirect medical education costs is proxy to account for a number of factors which may legitimately increase costs in teaching hospitals (House Ways and Means Committee Report, Number 98-25, March 4, 1983 and Senate Finance Committee Report, Number 98-23, March 11, 1983.)

As stated in the Administration's FY 1992 budget document:

> Gradually reduce the IME adjustment factor for prospective payment hospitals from 7.7 percent to 3.2 percent, starting in FY 1992. Percentages would be: FY 1992, 4.4 percent; FY 1993, 4.1 percent; FY 1994, 3.8 percent; FY 1995, 3.5 percent; and, FY 1996, 3.2 percent.

The Administration's proposal to reduce the IME adjustment would substantially harm the financial viability of teaching hospitals. Table 1 (attached), shows the impact of reducing the IME adjustment on the 1990 PPS margins of 65 members of the COTH using five different levels of the adjustment. To estimate the effect of reductions on PPS margins, each hospital's 1990 IME payment was adjusted using the various IME proposed reductions.

The first column in Table 1 shows 1990 PPS margins using all 1990 PPS revenues and all Medicare inpatient operating costs including the current IME adjustment percentage. PPS margins in column 2 are calculated using the Prospective Payment Assessment Commission's (ProPAC) FY 1992 recommendation of 7.0 percent for the adjustment, and column 3 shows resulting PPS margins if the adjustment were to be reduced to 4.4 percent as proposed by the Administration for FY 1992. PPS margins in column 5 represent the Administration's final objective of achieving an IME adjustment of 3.2 percent in FY 1996.

The PPS margins of these hospitals are highly sensitive to decreases in the level of the IME adjustment. Table 1 shows the average 1990 PPS margin was 3.8 percent using the current 7.7 percent IME adjustment, but declines to 1.7 percent, a reduction of 2.1 percentage points or approximately 71 percent, at the 7.0 percent IME adjustment level. It should be noted that these margins are overstated because capital and some other expenses are paid at less than full costs.

Individual hospitals' PPS margins decline at different rates depending on the relative contribution of the IME payment to the total PPS payment. If the IME adjustment is reduced, hospitals that are heavily dependent on IME payments will experience greater decreases in their PPS margins than hospitals that rely less on IME payments.

The AAMC is concerned that recent increases in the disproportionate share (DSH) adjustment, as mandated by OBRA 1989 and OBRA 1990, and analyses of the overlapping relationship between the IME and DSH adjustments have led some policy makers to conclude that teaching hospitals would not be harmed by a reduction in the IME adjustment. A reduction in the IME adjustment affects all teaching hospitals, reducing the margins for institutions regardless of their low-income patient share. Hospitals that do not receive DSH payments tend to have low or negative PPS margins at the current IME adjustment level. Five of the eight hospitals receiving no DSH payment in Table 1, reported negative PPS margins in 1990 with an IME of 7.7 percent.

Hospitals that receive DSH payments have consistently higher PPS margins and lower total margins than hospitals that do not receive DSH payments. Table 2 presents an analysis, by level of DSH payments, of the trends in PPS and total margins for the 110 COTH member hospitals that provided data for 1987-1989.

When these hospitals are grouped based on DSH payment as a percentage of total PPS payments, substantial differences in PPS and total margins across the subgroups are apparent. Using 1989 data, PPS margins varied from 2.3 percent in hospitals that received no DSH payment to nearly 20 percent in hospitals that received relatively high percentages of their total PPS payments from the DSH adjustment. However, hospitals with relatively high DSH payments had the lowest **total** margins of any group.

In recent years Congress has indicated the level of the IME adjustment should reflect the broader mission and overall financial viability of teaching hospitals to assure access and quality of care for Medicare beneficiaries and other patients. Total margins have remained consistently lower than PPS margins because factors other than PPS payments, such as uncompensated care, affect the overall financial performance of teaching hospitals. The AAMC strongly supports the consideration of overall financial performance, as measured by total margin, in determining the level of the IME adjustment.

ProPAC has also recognized that the financial success or failure of hospitals could affect access to care and quality of care received by Medicare beneficiaries and other patients. In its attempt to balance payments for services at the lowest cost to the Medicare Trust Fund with a level of payment that assures access to services of appropriate quality, the Commission has traditionally viewed the overall financial viability of teaching hospitals as one of several factors in making a recommendation on the level of the IME adjustment.

The Congress should also consider the financial impact of a reduction on hospitals that get small or no DSH payments and the effect of a reduction on quality and access to care. Hospitals that receive a relatively small share of their PPS payments from DSH will be more adversely affected by a cut in the IME relative to hospitals that receive DSH payments. A reduction in the IME adjustment would hinder teaching hospitals' future capability to support adverse selection within DRGs, high technology care, high cost services for referred patients, and unique community services such as burn and trauma units.

The AAMC strongly opposes any proposed reduction in the IME adjustment below its current level of 7.7 percent for each 0.1 increase in a hospital's resident to bed ratio.

HOSPITAL OUTPATIENT PAYMENTS

In 1989, COTH members provided 71 million outpatient and emergency visits. Although accounting for only 6 percent of the nation's hospitals, COTH members had 24 percent of all outpatient visits.

As stated in the Administration's FY 1992 budget document:

> Payments for ambulatory surgery, radiology, and diagnostic tests provided by hospital outpatient departments would be based on prospective rates. Payment for ambulatory surgery procedures would be based on a prospective rate set at a lower of average OPD costs, or the current ASC rate. Prospective rates for other ambulatory surgery procedures would be phased-in subsequently. Payment for radiology, diagnostic tests, and minor surgical procedures not on the ASC list would be based on the technical component of the physician fee schedule. The change for radiology would be implemented during FY 1992, the change for diagnostic and minor surgical procedures would be subsequently implemented. The same [prospective] rate would apply whether the service is provided in an OPD, an ASC, or a physician's office. The ASC fee update would be moved from July 1 to January 1 to conform with other Part B updates. These proposals have estimated savings of $50 million in FY 1992.

The Administration's proposal would disproportionately harm teaching hospitals and their outpatient clinics. COTH members generally have large clinics located in urban areas providing primary care services to meet community health care needs and offering primary care clinical education opportunities for medical students and residents. Teaching status, case mix, location, and manpower skill mix characteristics may require add-on adjustments to a prospective payment rate for teaching hospital OPDs and affiliated ASCs.

There are two types of facility payments for outpatient services based on setting: ambulatory surgery center (ASC) and the hospital outpatient department (OPD). The physician is paid the professional component, which is not part of the facility component. OBRA 1980 required payments to be made on the basis of prospectively set rates or "standard overhead amounts" for a specified list of ambulatory surgical procedures. These facility payments are referred to as ASC rates. The regulations implementing OBRA 1980 were not published until 1982. At that time, the implementing regulations specified that the rates would be based on a specified list of surgical procedures classified by payment groups. During the past 9 years, both the ASC list of procedures and the number of payment groups have been expanded considerably. Although OBRA 1986 required the ASC prospective rates to be updated annually, HCFA missed most update deadlines.

Until the passage of OBRA 1987, all OPD services were paid on an allowable cost basis. As an interim step towards a fully prospective rate for ambulatory surgery procedures provided in OPDs, the Congress agreed to extend the ASC payment rates for the ASC list services when provided in OPDs. This provision was effective October 1, 1987. OBRA 1987 requires OPDs to be paid the **lesser** of the hospital's reasonable costs or customary charges for the services, reduced by deductibles and coinsurance **or** a blend of the ASC portion and the hospital specific amount. Amendments to OPD payments were made during subsequent Congressional budget reconciliation years. Capital costs for hospital outpatient services and the hospital specific capital cost portion of the ASC blended amount are paid at 85 percent of costs. Beginning October 1, 1990, payments for outpatient services paid on a reasonable cost basis are reduced by 5.8 percent. In addition, beginning January 1, 1991, payments for ambulatory surgery and radiology services provided in outpatient departments are subject to an aggregate cost limit based on a blend of 42 percent of the hospital's costs and 58 percent of the fees paid for the same service provided in an ASC.

In OBRA 1990, Congress refocused DHHS's attention on hospital outpatient payment reform by requiring the secretary to develop a proposal to replace the current payment system for OPDs. The secretary's proposal must be based on prospectively determined rates and it must be submitted to the Congress no later than September 1, 1991. OBRA 1990 also requires ProPAC, in its March 1, 1992 report to Congress, to submit an analysis of the secretary's proposal and make recommendations on outpatient payment reform.

Hospital OPD payment reform has been delayed twice. OBRA 1986 required the Secretary of DHHS to develop a prospective payment system for the facility portion of ambulatory surgical procedures performed in OPDs. The payment system was scheduled to be implemented by October 1, 1989. In addition, by January 1, 1991, the secretary was required to report to Congress a model payment system for hospital outpatient services other than ambulatory surgery services. These deadlines were not met, thereby causing Congress to restate its request for a new outpatient payment system in OBRA 1990.

AAMC Reasons for Opposition

The AAMC currently opposes any changes in hospital outpatient payments.

- The AAMC believes that it is unwise and short sighted to change the payment system by implementing the Administration's proposal at a time when the secretary is developing a prospective payment system for outpatient services. Therefore, we urge no changes in outpatient payments until the secretary has developed, and ProPAC has studied and made recommendations on a comprehensive outpatient payment reform policy.

- While the secretary is developing an outpatient payment proposal, the implementation of physician payment reform is proceeding. Teaching hospitals are only beginning to understand the impact that RBRVS will have on physician fees. It is also unclear how those changes will affect teaching hospitals and their unique relationships with faculty physicians. The Administration's proposal will cause further uncertainty in the hospital outpatient setting.

TABLE 1: 1990 PPS MARGINS OF SELECTED ACADEMIC MEDICAL CENTER AND MAJOR AFFILIATED HOSPITALS AT VARYING LEVELS OF THE IME ADJUSTMENT
RANKED BY PPS MARGIN WITH IME @ CURRENT 7.7 PERCENT

	1990 PPS MARGINS WITH IME AT				
HOSPITAL	7.7%	7.0%*	4.4%**	4.1%	3.2%
A	39.9	39.2	36.0	35.6	34.5
B	37.7	36.4	31.1	30.4	28.3
C	34.8	33.6	28.7	28.1	26.2
D	34.4	33.3	28.4	27.8	25.9
E	33.7	32.4	27.3	26.7	24.7
F	32.3	31.1	26.3	25.7	23.9
G	31.3	29.8	23.8	23.1	20.7
H	30.5	28.8	21.9	21.1	18.3
I	26.0	24.3	17.0	16.0	13.1
J	25.7	23.6	14.9	13.8	10.2
K	22.2	20.4	13.0	12.1	9.1
L	21.2	20.2	16.1	15.6	14.1
M	20.4	18.3	9.2	8.0	4.3
N	18.6	16.6	8.0	6.9	3.4
O	16.4	13.9	3.5	2.1	-2.3
P	16.2	13.9	3.8	2.5	-1.6
Q	15.0	13.7	8.4	7.8	5.8
R	14.3	12.1	3.2	2.1	-1.5
S	13.9	12.1	4.6	3.7	0.8
T	13.1	10.6	0.2	-1.1	-5.5
U	12.9	10.9	2.4	1.3	-2.1
V	12.5	10.0	-0.7	-2.1	-6.5
W	12.5	10.4	1.6	0.5	-3.0
X	11.8	9.6	0.5	-0.7	-4.4
Y	10.7	8.8	0.9	-0.1	-3.3
Z	9.4	7.5	-0.5	-1.5	-4.6
AA	9.4	7.5	0.1	-0.8	-3.7
BB	8.4	5.8	-5.4	-6.8	-11.5
CC	7.4	5.1	-4.6	-5.8	-9.7
DD	7.3	4.9	-5.5	-6.8	-11.1
EE	7.0	5.0	-3.2	-4.2	-7.5
FF	6.9	4.9	-3.6	-4.6	-8.0
GG	6.2	3.9	-5.7	-6.9	-10.8
HH	4.8	2.6	-6.5	-7.6	-11.2
II	4.3	2.0	-7.4	-8.6	-12.3
JJ	2.3	1.0	-4.3	-4.9	-6.9
KK	2.0	-0.6	-11.5	-12.9	-17.4
LL	1.5	0.1	-5.6	-6.3	-8.5
MM	1.2	-1.3	-11.4	-12.7	-16.8
NN	1.1	0.8	-0.1	-0.3	-0.6

TABLE 1: **1990 PPS MARGINS OF SELECTED ACADEMIC MEDICAL CENTER AND MAJOR AFFILIATED HOSPITALS AT VARYING LEVELS OF THE IME ADJUSTMENT**
RANKED BY PPS MARGIN WITH IME @ CURRENT 7.7 PERCENT

	1990 PPS MARGINS WITH IME AT				
HOSPITAL	7.7%	7.0%*	4.4%**	4.1%	3.2%
OO	0.5	-1.6	-10.2	-11.3	-14.7
PP	0.2	-2.4	-13.0	-14.4	-18.7
QQ	-0.3	-1.1	-4.6	-5.0	-6.3
RR	-0.6	-2.6	-11.1	-12.2	-15.5
SS	-1.2	-3.6	-13.2	-14.5	-18.4
TT	-3.1	-6.3	-20.1	-22.0	-27.8
UU	-3.5	-5.9	-16.0	-17.3	-21.3
VV	-3.8	-6.1	-15.5	-16.7	-20.4
WW	-4.7	-6.5	-13.6	-14.5	-17.2
XX	-4.8	-7.0	-16.1	-17.2	-20.8
YY	-5.0	-7.3	-17.2	-18.4	-22.4
ZZ	-5.1	-5.7	-7.9	-8.2	-9.0
AAA	-6.2	-8.9	-19.8	-21.2	-25.7
BBB	-6.6	-9.4	-21.1	-22.6	-27.3
CCC	-7.3	-10.3	-23.2	-24.9	-30.3
DDD	-8.7	-10.9	-20.0	-21.1	-24.7
EEE	-9.1	-11.7	-22.7	-24.1	-28.5
FFF	-9.2	-12.3	-25.6	-27.3	-32.9
GGG	-11.6	-14.5	-26.7	-28.3	-33.3
HHH	-13.7	-15.8	-24.2	-25.3	-28.5
III	-14.1	-16.9	-28.6	-30.1	-34.8
JJJ	-14.5	-16.9	-26.9	-28.2	-32.1
KKK	-21.0	-23.7	-34.8	-36.3	-40.7
LLL	-22.6	-25.0	-35.0	-36.3	-40.2
MMM	-25.5	-27.5	-35.7	-36.7	-39.8
MEDIAN	6.2	3.9	-4.6	-5.8	-8.5
AVERAGE (WEIGHTED)	3.8	1.7	-7.0	-8.0	-11.5

* ProPAC recommendation for FY 1992.

** Administration budget proposal for FY 1992.

SOURCE: *ASSOCIATION OF AMERICAN MEDICAL COLLEGES FROM MEDICARE COST REPORTS AND FY 1989 AND FY 1990 SURVEY OF HOSPITALS' FINANCIAL AND GENERAL OPERATING DATA.*

TABLE 2

MEANS PPS AND TOTAL MARGINS OF SELECTED ACADEMIC MEDICAL CENTER MAJOR AFFILIATED HOSPITALS BY PERCENTAGE OF DSH PAYMENT: FY 1987 - FY 1989

		PPS MARGINS			TOTAL MARGINS		
	NUMBER OF HOSPITALS	FY 87	FY 88	FY 89	FY 87	FY 88	FY 89
ALL HOSPITALS	110	16.83%	11.96%	9.11%	3.54%	2.48%	2.43%
DSH AS % OF TOTAL PPS PAYMENTS							
No DSH Payment	18	13.52	2.18	2.26	5.26	3.94	4.35
Low (2.3 - 5.1%)	31	16.77	11.70	6.56	4.89	3.40	4.33
Med (5.3 - 9.3%)	31	15.89	12.71	9.64	3.10	1.85	1.27
High (9.4 - 17.2%)	30	22.02	21.29	19.83	1.22	1.07	0.15

COTH HOSPITALS PROVIDING DATA FOR IME ANALYSIS (Tables 1 and 2)

	HOSPITAL	CITY, STATE
*	University of Alabama Hospitals	Birmingham, Alabama
*	University of South Alabama Medical Center	Mobile, Alabama
	University Medical Center	Tucson, Arizona
	The University Hospital of Arkansas	Little Rock, Arkansas
*	Loma Linda University Medical Center	Loma Linda, California
+	Cedars-Sinai Medical Center	Los Angeles, California
	Los Angeles County-USC Medical Center	Los Angeles, California
	UCLA Medical Center	Los Angeles, California
	University of California, Irvine, Medical Center	Orange, California
	University of California, Davis, Medical Center	Sacramento, California
	University of California, San Diego, Medical Center	San Diego, California
	The Medical Center at the University of California, San Francisco	San Francisco, California
	Stanford University Hospital	Stanford, California
	Harbor-UCLA Medical Center	Torrance, California
*	University Hospital	Denver, Colorado
*	John Dempsey Hospital, University of Connecticut Health Center	Farmington, Connecticut
*	Saint Francis Hospital and Medical Center	Hartford, Connecticut
*	Yale-New Haven Hospital	New Haven, Connecticut
	Georgetown University Hospital	Washington, D.C.
*	Howard University Hospital	Washington, D.C.
*	The George Washington University Hospital	Washington, D.C.
	Shands Hospital	Gainesville, Florida
*	Mount Sinai Medical Center	Miami Beach, Florida
*	Grady Memorial Hospital	Atlanta, Georgia
	Crawford Long Hospital of Emory University	Atlanta, Georgia
*	Emory University Hospital	Atlanta, Georgia
	Medical College of Georgia Hospital and Clinics	Augusta, Georgia
*	Illinois Masonic Medical Center	Chicago, Illinois
	Mercy Hosptial and Medical Center	Chicago, Illinois
	Michael Reese Hospital and Medical Center	Chicago, Illinois
*	Northwestern Memorial Hospital	Chicago, Illinois
	Rush-Presbyterian-St. Luke's Medical Center	Chicago, Illinois
	University of Chicago Hospitals	Chicago, Illinois
	Foster G. McGaw Hospital	Maywood, Illinois
+	Lutheran General Hospital	Park Ridge, Illinois
*	William N. Wishard Memorial Hospital	Indianapolis, Indiana
	Indiana University Hospitals	Indianapolis, Indiana
	University of Iowa Hospitals and Clinics	Iowa City, Iowa
	University of Kansas Hospital	Kansas City, Kansas
	University Hospital, University of Kentucky Medical Center	Lexington, Kentucky
	Humana Hospital-University of Louisville	Louisville, Kentucky
	Tulane Medical Center Hospital	New Orleans, Louisiana
	Louisiana State University Hospital	Shreveport, Louisiana
	The Johns Hopkins Hospital	Baltimore, Maryland

+ Table 1 only.
* Table 2 only.

COTH HOSPITALS PROVIDING DATA FOR IME ANALYSIS (Tables 1 and 2) (continued)

HOSPITAL	CITY, STATE
• Beth Israel Hospital	Boston, Massachusetts
Massachusetts General Hospital	Boston, Massachusetts
New England Medical Center, Inc.	Boston, Massachusetts
• Brigham and Women's Hospital	Boston, Massachusetts
• University Hospital	Boston, Massachusetts
• Baystate Medical Center	Springfield, Massachusetts
University of Massachusetts Hospital	Worcester, Massachusetts
University of Michigan Hospitals	Ann Arbor, Michigan
• Henry Ford Hospital	Detroit, Michigan
The University of Minnesota Hospital and Clinics	Minneapolis, Minnesota
University Hospital, University of Mississippi Medical Center	Jackson, Mississippi
University of Missouri Hospital and Clinics	Columbia, Missouri
Truman Medical Center	Kansas City, Missouri
St. John's Mercy Medical Center	St. Louis, Missouri
• The Jewish Hospital of St. Louis	St. Louis, Missouri
• The University Hospital	St. Louis, Missouri
• Barnes Hospital	St. Louis, Missouri
• St. Joseph Hospital	Omaha, Nebraska
University of Nebraska Hospital	Omaha, Nebraska
Mary Hitchcock Memorial Hospital	Hanover, New Hampshire
University of New Mexico Hospital	Albuquerque, New Mexico
• SUNY Health Science Center, University Hospital	Brooklyn, New York
• Montefiore Medical Center	Bronx, New York
• Buffalo General Hospital	Buffalo, New York
• Nassau County Medical Center	East Meadow, New York
• Beth Israel Medical Center	New York, New York
• Presbyterian Hospital in the City of New York	New York, New York
• St. Luke's-Roosevelt Hospital Center	New York, New York
• The Mount Sinai Hospital	New York, New York
• Tisch Hospital, New York University Medical Center	New York, New York
• University Hospital	Stony Brook, New York
• University Hospital, SUNY Health Science Center, Syracuse	Syracuse, New York
University of North Carolina Hospital	Chapel Hill, North Carolina
Duke University Hospital	Durham, North Carolina
North Carolina Baptist Hospital, Inc.	Winston-Salem, North Carolina
University of Cincinnati Hospital	Cincinnati, Ohio
• MetroHealth Medical Center	Cleveland, Ohio
• University Hospitals of Cleveland	Cleveland, Ohio
The Ohio State University Hospitals	Columbus, Ohio
Medical College of Ohio Hospitals	Toledo, Ohio
Oklahoma Medical Center	Oklahoma City, Oklahoma
Oregon Health Sciences University Hospital	Portland, Oregon
PennState University Hospital, The Milton S. Hershey Medical Center	Hershey, Pennsylvania
• Hahnemann University Hospital	Philadelphia, Pennsylvania
Hospital of the Medical College of Pennsylvania	Philadelphia, Pennsylvania
Hospital of the University of Pennsylvania	Philadelphia, Pennsylvania

+ Table 1 only.

• Table 2 only.

COTH HOSPITALS PROVIDING DATA FOR IME ANALYSIS (Tables 1 and 2) (continued)

	HOSPITAL	CITY, STATE
*	Temple University Hospital	Philadelphia, Pennsylvania
	Thomas Jefferson University Hospital	Philadelphia, Pennsylvania
	Allegheny General Hospital	Pittsburgh, Pennsylvania
+	Mercy Hospital of Pittsburgh	Pittsburgh, Pennsylvania
	Presbyterian Medical Center University Hospital	Pittsburgh, Pennsylvania
	Medical University Hospital	Charleston, South Carolina
*	Regional Medical Center at Memphis	Memphis, Tennessee
	Vanderbilt University Hospital	Nashville, Tennessee
+	Baylor University Medical Center	Dallas, Texas
*	Dallas County Hospital District, Parkland Memorial Hospital	Dallas, Texas
*	The Methodist Hospital	Houston, Texas
	Hermann Hospital	Houston, Texas
*	The University of Texas Medical Branch Hospitals at Galveston	Galveston, Texas
	University of Utah Hospital	Salt Lake City, Utah
*	Medical Center Hospital of Vermont	Burlington, Vermont
	University of Virginia Hospitals	Charlottesville, Virginia
	Medical College of Virginia Hospitals	Richmond, Virginia
	University of Washington Medical Center	Seattle, Washington
*	University of Washington Hospitals, Harborview Medical Center	Seattle, Washington
*	Charleston Area Medical Center	Charleston, West Virginia
*	West Virginia University Hospital, Inc.	Morgantown, West Virginia
	University of Wisconsin Hospital and Clinics	Madison, Wisconsin
*	Froedtert Memorial Lutheran Hospital	Milwaukee, Wisconsin
*	Milwaukee County Medical Complex	Milwaukee, Wisconsin

+ Table 1 only.
* Table 2 only.

STATEMENT OF DAVID SATCHER, M.D., PH.D., PRESIDENT, GEORGE W. HUBBARD HOSPITAL, MEHARRY MEDICAL COLLEGE, NASHVILLE, TENN., ON BEHALF OF ASSOCIATION OF MINORITY HEALTH PROFESSIONS SCHOOLS

Mr. Chairman and members of the Subcommittee, I am Dr. David Satcher, the President of the George W. Hubbard Hospital and Meharry Medical College in Nashville, Tennessee. I appreciate the opportunity for the Association of Minority Health Professions Schools to submit written testimony for the hearing record on hospital payment by the Medicare program.

The Association of Minority Health Professions Schools works closely with the Coalition on Black Hospitals and Health Services. The Coalition is a recently formed advocacy group consisting of Black hospitals whose purpose is to improve the plight of black hospitals. I would like to focus on the important role that black hospitals have in treating the poor and therefore have in treating Medicare recipients.

Historically Black Hospitals have traditionally played a major role in serving the health care needs of Blacks and other minorities in this country. At the turn of the century 200 Black hospitals existed in the United States, providing medical treatment to poor Blacks who were discriminated against and who had no other source of health care and modest means of paying for their treatment. These hospitals were established to respond to the unmet national health needs of the poor and underserved - a need which was not being addressed by the existing health care system. Because of their unique patient populations these institutions endure a financial struggle which is inherent in their mission. Because the patient populations served by these institutions have been historically poor, they have not earned sufficient money from the process of patient care. Historically, these institutions not only provided health care for an underserved population, but also provided employment, equal opportunity and access to the higher levels of management as well as supervisory and research capabilities for black health care professionals in all levels of management, research and service.

The number of historically black hospitals has dwindled to 11. Impoverishment over a century has taken its toll. Black hospitals are in the red and are experiencing severe financial duress. All may have to close.

Yet the national need to provide quality health care for Blacks and other minorities in this country is greater than ever. The 1985 Report of the Secretary's Task Force on Black and Minority Health revealed striking health status disparities among Blacks when compared to Whites. Life expectancy for Blacks is about 8 years less than that of Whites. Infant mortality is double the rate for Blacks than it is for Whites. Blacks also suffer disproportionately high rates of cancer, hypertension, diabetes, and other major disease categories than do Whites. Since the 1985 report it is shocking to note that the health status disparity has increased. AIDS which was not even mentioned in the 1985 report is now a leading cause of death and disproportionately affects blacks and other minorities - minorities who constitute 24% of the population but 45% of the AIDS victims. And black life expectancy has actually decreased from 69.7 in 1984 to 69.2 in 1988. In spite of new reimbursement systems, increased regulation and new definitions of medicaid eligibility, the black hospital remains an essential bastion of health care for the poor, indigent, and underserved.

The United States has the best health care services in the world - but only for those who can afford it. 37 million Americans, a disproportionate share of whom are Blacks or other minorities, cannot afford adequate health care or do not have access to health care services. It is estimated that while 74% of White Americans have health insurance, only 62% of Black Americans have health insurance. With the remaining 11 Black hospitals in the U.S. seriously considering closing their doors because of fiscal impoverishment, policy makers must make some fundamental decisions:

(1) Can the nation afford to lose these valuable health care facilities when the health status of Blacks is at such a low level?

(2) If these hospitals go under, what resources will provide the necessary health care to the millions of people who are served by these institutions?

(3) Is there a bona fide federal commitment to ensuring that these hospitals become viable?

(4) If so, how can policy makers begin the process of insuring that these hospitals are able to provide the access to health care necessary to improve the health status of **all** Americans?

The imminent demise of the black hospitals in America is an alarming and unacceptable situation. The significant difference in patients served by black-owned hospitals is that since more blacks are unemployed or underemployed and uninsured than the general population, they are least able to afford medical care. While the average white patient makes 4.4 visits annually to see a physician, blacks make 3.4 annual visits. Lack of preventive treatment for blacks and other minorities exacerbates sickness. There are other variables that have an impact on the disparities. For example, blacks tend to have more hazardous occupations, improper environmental exposures and less knowledge of health practices and healthy lifestyles than the general population.

Compounding these disadvantages is the severe underrepresentation of blacks and other minorities in the health professions. Blacks constitute 12% of the population but less than 3% of physicians, dentists, pharmacists and veterinarians. This is important in that data clearly show that blacks and other minorities are more likely to practice in underserved communities, more likely to care for other minorities and more likely to accept patients who are Medicaid recipients or otherwise poorer than the general population.

Years of segregation set the stage for an inability to compete and survive. Our institutions were never able to accumulate the surplus capital needed to replace worn out facilities or keep pace with modern day technology. The arrival of DRGs only exacerbated an aggravated situation. Without capital resources to acquire, upgrade and maintain equipment and facilities, recruit and retain adequate professional, paraprofessional and administrative staff - black hospitals cannot possibly be expected to compete effectively. While these hospitals may appear to function as public institutions in that they treat people without the means to pay, they are not publicly-owned. Otherwise their mission, their range of services and their patients are indistinguishable from any city, state or federal institution. Yet they do not receive the same subsidy. While most U.S. voluntary hospitals make claim to non-profitability and worry about the burden of competition, absolutely no one competes for the privilege to treat the poor. In this regard, our institutions are truly "sole source providers." What is needed is a coordinated set of health, social and educational programs which will meet the health care needs of blacks and the financial needs of black hospitals.

The plight of black hospitals is a concern to the Medicare program because of the critical role these hospitals play in treating the poor. Because the issue of total reimbursement to black hospitals is so critical, any changes in hospital payment by the Medicare program must be made with the financial concerns of these hospitals in mind.

What is needed is a refocusing of the federal government's health priorities as they related to black hospitals which provide essential care to underserved blacks. The Department of Health and Human Services' Council on Graduate Medical Education recently issued a report on the financial status of teaching hospitals. One of that report's recommendations were that adequate levels of Medicare payment must be made to enable teaching hospitals to deliver patient care and offer exemplary teaching programs to students and residents. The report recommended that in addressing health care policy, the impact of policy must be made with specific regard to the financial status of teaching hospitals.

Despite an increasing rise in per capita health care spending, the health care needs of Blacks continue to go unmet. The federal government must continue to address the health status disparity between blacks and other minorities and the general population and specifically must address the issue of uncompensated care through improved access to health care for blacks and minorities. Improving the fiscal solvency of Black hospitals is an essential component in addressing these related issues.

Thank you for the opportunity to present the views and recommendations of the Association of Minority Health Professions Schools.

WRITTEN STATEMENT OF
THOMAS DETRE, M.D., PRESIDENT
UNIVERSITY OF PITTSBURGH MEDICAL CENTER

My name is Thomas Detre, M.D., and I am President of the University of Pittsburgh Medical Center. The University of Pittsburgh Medical Center is an academic medical center dedicated to a three-fold mission of biomedical research, education and training, and clinical care.

First, I would like to thank the House Ways and Means Subcommittee on Health and its Chairman, Congressman Fortney Stark, for their dedication in addressing the needs of the national health care industry in a fair and even-handed manner. The rising cost of delivering health services coupled with national budget constraints make meeting the health needs of the American people an overwhelming challenge to health professionals and legislators. I commend this subcommittee for its hard work and commitment.

A number of changes have occurred in the health care industry over the past decade which have led business, government, and health care leaders to search for innovative methods of providing health services to the community. Among these changes are increased costs associated with medical technology, the lack of health insurance for nearly 37 million Americans, and the demographic changes in this country. The national expenditure on health care is projected to reach 15% of the GNP by the year 2000. In the meantime, the aggregate PPS margin for hospitals has decreased over the past few years and is expected to remain at a lower level for the near future.

The United States Congress, in an effort to address the health concerns of the nation, has sought legislative remedies to curtail the annual health expenditure of the country. In 1983, with passage of the Social Security Amendments Act, hospitals were no longer reimbursed by a retrospective cost-based system. Instead, this Act led to the implementation of the prospective payment system (PPS) in which hospitals receive payment for services on a prospective basis. Hospitals have, on average, cooperated with the new reimbursement system and, as a result, the PPS has met with moderate success in slowing the rate of growth of federal expenditures on inpatient hospital costs since its implementation.

In addition, as mandated by the Omnibus Budget Reconciliation Act (OBRA) of 1987, the Health Care Financing Administration (HCFA) has published proposed rules for the payment of inpatient hospital capital costs under a PPS. While I appreciate the hard work of HCFA in devising a transition period for hospitals to adjust to the new system, I am concerned that, once fully implemented, this new system of reimbursement may become the target of budget-driven policies much like other parts of the PPS.

One component of the PPS payment to hospitals with an approved medical education program is the indirect medical education (IME) factor. This component comprises a significant portion of hospital reimbursement and provides for a most important aspect of comprehensive health care -- the training of new physicians. The suggestion that this PPS component be cut from 7.7% to 1.9% (as initially recommended by the Prospective Payment Assessment Commission [ProPAC] for FY 1992) would result in a loss of approximately $13.5 million to Presbyterian University Hospital in Pittsburgh. The Bush Administration's budget proposal to reduce the IME factor from 7.7% to 4.4% for FY 1992 would result in a $8-9 million loss to Presbyterian University Hospital. These reductions may result in a net savings in the national budget, but at what cost to the health needs of American citizens and the future delivery of medical care?

The area wage index, which is used to adjust the hospital's payment amount for the wage level of the hospital's area, has been slow to adjust for the changing labor force in the health care industry, resulting in underpayment to some hospitals. I anticipate improvements in this calculation with the establishment of the Medicare Geographic Classification Review Board, and I look forward to these changes.

The U.S. Congress has struggled to curtail the amount of federal dollars spent annually on health care in the United States. Policymakers, business leaders, and health industry leaders have recognized the benefits of addressing the problems of this industry in a cooperative fashion. Unfortunately, legislative successes notwithstanding, there remain a multitude of problems associated with the industry including health care costs and accessibility.

Cost containment and accessibility in the health care industry will remain the top priority for many throughout the coming decade. Suggested cost-containment models that the nation could pursue include both the Canadian and British national health plans, as well as health care rationing models that some states have attempted to implement. Each of the above mentioned systems would be problematic to impose on a national scale in the United States. The national health systems in Canada and Great Britain, while affording the citizens of these countries access to health care, do not allow for the medical advances found in the United States. A national policy of rationing health care in the United States would prove both ethically and morally difficult to justify and therefore would be difficult to implement.

Clearly, in addition to technical adjustments of the Medicare system, changes in the health care industry must occur in the near future. Budget-driven domestic policies and rationing of health care services do not seem to be workable solutions to the dilemma facing the United States. In this Congress, without the pressures of a budget reconciliation package, let us work together, with the individual and health care provider in mind, to find solutions to the health care problems of this nation.

○